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## ORIGINAL ARTICLES.

### ACUTE NASOPHARYNGEAL INFLAMMATION.

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FOUNDLING ASYLUM AND TO THE INFANT ASYLUM.

THIS inflammation has increased in frequency and severity during the latter half of the nineteenth century. Changes in the frequency or type of a disease are not infrequent during cycles in its history, without any appreciable cause, but as regards the malady under consideration, its increased frequency and severity are plainly due in great measure to diphtheria and influenza, from which our ancestors suffered but little.

Acute nasopharyngeal inflammation occurs in several distinct diseases, but with such similarity that we feel justified in considering it as one disease. Rhinologists and throat specialists treat of this malady at length, both in its acute and chronic forms, but their kinds of apparatus are too cumbersome for family use, and the patients with the acute form of inflammation are, many of them, too sick to leave their beds. I shall endeavor to point out the treatment which I have found most useful in nursery cases.

**Etiology.**—We are able to designate several causes of nasopharyngeal inflammation. It is a common experience that sudden exposure to wet and cold when the body is scantily clad, especially if it be perspiring and overheated is followed by nasopharyngeal catarrh. "Taking cold" signifies in most instances that the person, with or without a chilly sensation, has a nasopharyngeal catarrh, characterized by a thin mucous, and afterward, perhaps, by a mucopurulent discharge from the nostrils and throat. If the opinion as regards the cause be correct, and no other inflammations, as tonsillitis, laryngitis, or bronchitis, supervene, the patient soon recovers. Obviously this malady is non-microbic.

Chemical or finely divided mechanical irritants inhaled in each inspiratory act also produce nasopharyngeal catarrh. Such irritants are obviously more abundant in a large city, with its many business transactions, than in the purer air of the country. If a sunbeam be allowed to enter a darkened room, numerous floating motes will be

seen in it; and if on a cloudless and quiet day an observer stand at a distance from the city limits, he will see a dense mist or cloud resting over the entire city, and no doubt composed largely of such particles as float in the sunbeam. D. F. Lincoln, M.D., in his paper on the atmosphere, in Volume xviii of Ziemssen's Cyclopaedia, page 636, says: "African organisms have been found in the air of Berlin. . . . The animal and vegetable kingdoms furnish a great variety of material for dust. . . . Bacteria, vibriones, and monads are found very frequently. . . . also fragments of insects are found." Probably an equally thorough examination would disclose similar impurities in the atmosphere of American cities. Motes floating in the air may convey fragmentary animal, as well as vegetable forms, and minuter objects seen only by the microscope, as the pollen of flowers, which is the admitted cause of catarrhus aestivus, or hay-fever, may be similarly conveyed. These substances inhaled necessarily produce more or less irritation and sensitiveness, and, in some instances, catarrh of the upper air-passages.

At the present time, probably the most common cause of nasopharyngeal catarrh in this country is the influenza, which produces multi-form symptoms and lesions in the different organs, but according to my observations the primary lesion of influenza, in a large proportion of cases, is the catarrh of which we are treating, so that if two or more have this catarrh simultaneously in a family, and we are able to exclude measles and pertussis, the disease is probably influenza.

Influenza is not a new malady; our ancestors mentioned it. Sir Henry Holland wrote of it sixty years ago; but as scarlet fever was regarded as a mild, even trivial, malady in the time of Sydenham, so the influenza may have attacked our ancestors more mildly and for a shorter time than it has in Europe and America in the last six or seven years.

The smallness and portability, by currents of air, of the influenza bacillus enables it to enter the system readily by the usual modes of infection. Gaining entrance into and circulating in the blood, it is enabled to reach most of the organs, and there is probably no organ which has not experienced its irritating effect. Delafield and Prudden say: "There may be conjunctivitis, otitis, naso-

pharyngeal catarrh, tonsillitis, laryngitis, bronchitis, pneumonitis, pleuritis, gastritis, enteritis, or peripheral neuritis." A recent writer in a London medical journal enumerates as many more local maladies which result from influenza, and adds: "Mental incapacity remains long, and many patients affected in middle life speak of inability for bodily and mental work that was easy previously."

Observations have accumulated sufficiently to show that the minute bacilli of influenza have the power to penetrate the accessory tubes, sinuses, and deflections pertaining to the nasopharyngeal tract to a greater extent, probably, than any other pathogenic germ. They sometimes lodge upon the turbinated bones, enter the antrum of Highmore, Eustachian tubes, the middle ear, mastoid cells, the sphenoid and ethmoid sinuses, and, in those old enough, the frontal sinuses, producing unusual inflammations, with much suffering.

Cases might be related in confirmation of this statement. Thus, a man of good constitution and habits, attended by me, had such severe pain low in his forehead that he walked hurriedly, half-dressed, from one side of the room to the other, compressing with both hands the seat of the pain and moaning at each step. When the pain began to abate, he noticed distinctly a rubbing sensation when one of his eyes was moved in its socket—a sensation like that produced by rubbing the finger over a dry pane of glass. The inference was that the specific inflammation had extended to the frontal sinuses, and from them through the thin layer of bone to the orbit.

I shall relate one other case, reported in the London *Lancet*, October 19, 1895, showing how severely the accessory sinuses and cavities of the nasopharyngeal tract suffer from inflammation produced by the influenza bacillus, which apparently, in this case, entered the system through the nares and produced a severe, painful, and protracted inflammation of the antrum of Highmore. The patient, an adult, had constant pain in the left temporal, mastoid, and occipital regions since an attack of influenza, seven years previously. There was also a purulent discharge from the left nostril. On rhinoscopic examination, the anterior part of the left turbinated bone was found to be covered with small sessile vascular polypi, and the oozing of offensive pus from the middle meatus was constant. The amount of pus varied, and at night it ran down the throat. The carious teeth were extracted, and two holes were drilled into the antrum. A pyogenic membrane, forming a very complete cast of the central cavity, was removed,

along with pus and caseous matter, through the opening in the antrum. Polypi were removed and their bases cauterized. Patient was soon well.

These cases show the tendency of nasopharyngeal catarrh to extend into collateral tubes and sinuses, producing severe and dangerous inflammatory lesions, unless promptly relieved by treatment. Pathological researches are so far advanced that we can now assert that the following diseases, which are attended by nasopharyngeal inflammation, have a microbic cause: Influenza, measles, pertussis, scarlet fever, diphtheria, pseudo-diphtheria, erysipelas, gonorrhea and syphilis.

It is a fact of clinical importance, as expressed by Delafield and Prudden, that "acute inflammation of the lymph-nodes usually occurs in connection with some inflammatory process in the region from which its lymph is gathered." The lymph gathered from the inflamed nasopharyngeal surface in an acute infectious disease, like scarlet fever or diphtheria, contains not only the specific microbes of the disease, but other microbes, notably the streptococcus and staphylococcus (Booker and others) and the toxins produced by them. These, conveyed in the lymph-current, are highly irritating, causing inflammation in the lymphducts and nodes (adenitis), and in the adjacent connective tissue (cellulitis). If the inflammation in an infectious disease be pharyngeal, and antiseptic treatment of the fauces be not used, a swelling usually forms along one or both sides of the neck, often of the size of a hen's egg, or larger, and if the skin becomes red upon the swelling, suppuration inevitably occurs. This common complication, which might be prevented by the early and frequent use of local disinfection, increases the emaciation and weakness and renders the prognosis more doubtful.

*Symptoms.*—The constitutional symptoms are mild or severe, according to the gravity of the inflammation and the nature of the primary disease, if one be present. If the nasopharyngitis be active and pretty general, fever, thirst, and anorexia occur. Frontal headache is common, from the proximity of the inflammation to the head or its extension to the frontal sinuses. Sneezing is the first symptom in many cases of coryza. As the inflamed membrane swells, more or less obstruction occurs to respiration. The breathing is noisy, especially during sleep, and in severe cases the patient is compelled to breathe through the mouth. If there be much obstruction to respiration, the suffering of the patient is considerable, from the sensation of fulness in the

nostrils, the headache, and the muscular effort required in each respiratory act.

In the commencement of coryza, the patient experiences a sensation of dryness in the nostrils, which is soon succeeded by a thin discharge of serous appearance. In the course of a few hours the secretion becomes mucopurulent and thicker. If the case becomes chronic, more or less persistent thickening of the mucous membrane and incrustations are likely to occur. One of the most dangerous of the acute and nasopharyngeal inflammations is that occurring in latent diphtheria. I allude to cases in which the visible part of the nostrils and fauces does not exhibit pseudo-membrane but a catarrhal inflammation, while a pseudo-membrane probably occupies the posterior nares, a location which is very favorable for disseminating diphtheria. In such cases early and local antiseptic treatment is very important.

*Treatment.*—I need not remind the reader that, even with microscopic examination, it is impossible in many cases to make a clear and positive diagnosis of the nature of an attack of nasopharyngeal inflammation until one or more days have elapsed, and yet there is no other disease that requires a more early diagnosis. Inasmuch as a large proportion of cases of nasopharyngeal inflammation have a microbic origin, antiseptic sprays or inhalations should ordinarily be used every hour or half-hour from the first visit. Other appropriate remedies should be prescribed subsequently, as the nature of the attack becomes apparent. Young infants having this malady often necessarily respire through the mouth, on account of the mucopurulent secretion, thickening infiltration and incrustations of the Schneiderian surface. This impediment to normal breathing through the nostrils obviously compels respiration through the mouth, so the amount of food taken is diminished. Loss of flesh and strength inevitably result in young infants who take their food by suction, unless the nasal inflammation be soon relieved.

It is evident from the nature of nasopharyngeal inflammation that, though its causes vary, non-irritating antiseptic and germicidal applications should, as we have said above, be used from the first, and at short intervals, with an appropriate atomizer, small nasal syringe, small cotton swab, camel's-hair pencil, or other convenient instrument. Even when the cause is exposure to cold, the inhaled air is often so full of microbes that antiseptic applications are indicated.

The temperature of the room should be maintained at about 73° and the air be moist. I have

employed with apparent benefit the following mixture for supplying moist air to the nursery when nasopharyngeal disease is present :

R	Ol. Eucalypti	} aa	§ i
	Acidi Carbolici		
	Terebinthinæ		
	Misce.		§ viii

In hot weather, two towels of ordinary size, wrung out of hot water, should be spread at length on a table, with one or two newspapers underneath, and two tablespoonfuls of the above mixture sprinkled over them. This should be repeated every fourth hour. If the weather be cold, the two tablespoonfuls may be added to two quarts of water in a tin, zinc, or other vessel having a broad surface, and maintained at a temperature of 170° to 190° F., which causes simmering, but not boiling. This disinfects the air that is respired and, at the same time, renders it moist. This treatment may be properly continued during the active period of the inflammation.

Common mild attacks of coryza require simple treatment. The bowels should be kept open and the body comfortably clothed. Inunction of the nostrils with carbolized vaselin is a popular remedy, and it seems to give some relief. A five per cent. solution of common salt in warm water, injected into the nostrils with a small syringe, aids materially in removing the muco-pus, which obstructs the respiration.

The following formulæ are also useful in the treatment of naso-facial inflammations :

R	Acidi Boraci	3 i
	Sodii Biborat	3 ii
	Aquæ	§ viii
	Misce.	
R	Sodii Chloridi	3 i
	Sodii Biborat	3 ii
	Aquæ	℥ i
	Misce.	

Either mixture should be used hourly, or at longer intervals, as a spray for the nostrils and fauces. But while other sprays are useful, the following formula will be found eminently satisfactory for the purposes for which sprays are employed. I have recommended it for many patients, and to physicians, who have, so far as I recollect, uniformly reported favorably.

R	Creosoti Morson's Beechwood	gtt. ii-iii
	Seiler's Tablets (alkaline and antiseptic)	i-ii
	Aquæ Distillat	§ iii
	Misce.	

With a simple hand atomizer spray nostrils and throat every hour to two or three hours, compressing the bulb from four to six times, and inhaling deeply the inspired vapor.

The following is a similar formula, and might in some instances be substituted for Seiler's solution :

B	Creosoti Morson's Beechwood . . .	gtt. ii-iii
	Dobell's Solution . . .	℥ i
	Aquæ Puræ . . .	℥ iii
	Misce.	

Of course the measures for local use which we have recommended, can be safely employed by families before or between the physician's visits. All are aware, as we have stated elsewhere, that internal treatment also may be required, according to the nature of the nasopharyngeal catarrh and the exigencies which may arise.

#### SYDENHAM'S CHOREA; AN ANALYTICAL STUDY OF 125 CASES.

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CHOREA is a very old and familiar affection. It has been recognized as an entity almost since the days of prehistoric medicine. It has attracted the attention, as a field for study, of many medical men eminently qualified in clinical and pathological research, and yet there are several unsettled problems which remain to confuse our conception of the pathogenesis, and render uncertain the results from treatment. Our knowledge of the pathology involved is most indefinite and unsatisfactory. No two autopsies reflect the same findings, although minute punctiform hemorrhages, or minute emboli of the cortical vessels, with more or less congestion, have been noted with suggestive frequency by different observers. A theory of microbic origin has also its adherents, though facts are few. The etiology and pathogenesis will be easily deducible, reasoning from effect to cause, when once the pathology is established, and a more rational basis of treatment will also be attained as a correlated result. Clinical facts often indicate or suggest a line of pathological investigation, sometimes with happy results. Analytical studies of a series of cases, made with this object, are, therefore, often of much value.

During the years 1893-95, I saw in private practice and at my clinic at the New York Polyclinic, 125 cases of simple or Sydenham's chorea. In nearly all of these cases full record was made of the facts, as far as could be determined, of heredity, age at onset of first attack, exciting cause, month of onset both as to primary and relapsing attacks, number of relapses, distribution of movements, mental condition, presence or absence of personal rheumatism or heart disease,

and various special symptomatic conditions noted in individual cases. Of these 125 patients, 45 were males, 80 were females. The average age at the time of observation was 9¾ years, the youngest patient aged two years, the oldest (relapsing case), twenty-eight years old. Including parental phthisis, about one-fourth showed distinct lineal neurotic heredity as follows: Epilepsy 3, chorea 15, migraine 5, phthisis 5, insanity 1, total, 29. One patient, a girl, aged eight years, presented a history illustrating the most intense neurotic saturation in a family I have ever noted. Her father suffered from migraine, the mother was an epileptic, dying from an accident, a sister had chorea, a brother some form of paralysis, which I concluded from the description to have been poliomyelitis, and a maternal aunt died insane.

The exciting cause could not be determined in the majority of instances, but the number of cases in which the first symptoms of chorea quickly followed some one of the various infectious diseases of childhood, and particularly scarlet fever, was remarkable. Three followed grip, 1 the mumps, 5 measles, and 20 scarlet fever. In 4 cases there was a clear history of trauma involving injury to the head or concussion. Fright, or anger, or other emotional disturbance, was ascribed as the cause in 17 cases, and in one of my private patients, a young girl of thirteen, the symptoms (first attack) developed abruptly while in the theater, from the sudden, complete, accidental darkness, which resulted from some defect in the lighting apparatus. Her attack lasted seven weeks and was quite severe, the child having to be fed by an attendant for a time on account of the excessive violence of the ataxic movements. In 7 cases the disease manifested itself at the period of puberty, and no other cause was assignable, but it is to be noted that in three of these cases there was a neurotic heredity. Thirty cases began in the spring months (March 7, April 8, May 10, spring 5); 30 in the summer (June 8, July 10, August 4, summer 8); 5 in the fall (September 2, October 1, November 1, fall 1); and 12 during the winter months (December 3, January 3, February 6). In the remaining 48 cases the month or season could not be positively determined.

The distribution of the choreic movements was carefully noted in 101 cases, being limited to the left side in 19, to the right in 18, and involving both sides, with but slight differences in degree, in 64. As a rule, only one side was affected in patients with primary attacks, while the more frequent the relapses the greater the tendency to

general involvement. The speech and movements of the tongue were affected in 14 patients. The coexistence of heart disease and a history of rheumatism were points of special inquiry. In many instances suspected cardiac lesions were submitted to Professor Page of the department of diseases of the heart and lungs, for opinion. In no case was a history of vague limb, or muscle, or joint, or "growing" pains, accepted as rheumatic, only the frank, explosive manifestations of this disease being considered. Nine patients gave histories of well-defined attacks of rheumatism, and in one patient, a girl aged eight years, there was a history of three such attacks, chorea being present concurrently in one of them. Of those with well-marked evidences of cardiac disturbance, 11 presented conditions of organic disease, 3 of these cases of aortic regurgitation. In 8 cases there was more or less marked disturbance of the heart's function and rhythm, but no positively demonstrable lesion. All of these 8 cases exhibited a pulse-rate above the normal. The mental condition was noted in all cases, and in 75 no variation from the normal average in intelligence and psychological equilibrium for age was apparent. In 34 cases the mental state was far above the average, these children being of the precocious type, excelling in their studies and in some instances evidencing a high order of psychical activity and development. Only 7 were noted as "dull," and only 4 as exhibiting mental states which would justify the application of the term demented, and even here, in 2 cases, the term was open to criticism in its strictly technical significance. Other mental perversions noted were extreme irritability in 3, hysteria in 1, and rather intense melancholy depression in 1, a girl of fourteen. Most of these cases presenting variations from the normal, in the mental state were patients in whom one or more relapses had occurred.

Of the entire number of cases, 125 in all, there was a history of at least two attacks in 54, three attacks in 17, and four or more in 6 patients. Among the anomalous or unusual symptoms noted was optic atrophy, distinctly present in one case, and a mild optic neuritis in another. Insufficiency of the eye muscles, esophoria, astigmatism, and other minor anomalies of the visual apparatus were noted in several cases. Strabismus was present in decided form in 4 patients. A history of enuresis was volunteered in 4 cases and was probably present in others, but not noted, as no special inquiry was made with regard to it. Anemia, more or less profound in degree, was exceedingly common. Paralysis of the extremities was

not observed in a single case, even in minor degree, although several patients, through anemic exhaustion, or the extreme ataxic jerkings of the limbs, were rendered helpless. Atrophy of the muscles, observed in three cases by Rondot,<sup>1</sup> I have never seen present in Sydenham's chorea.

A recapitulation and comparison with the observations of others may not be without interest and value. As regards sex, I found the proportion to be about two females to one male (45 males, 80 females). All statistics show a peculiar susceptibility in females as compared with males. Wharton and Vickery,<sup>2</sup> in a study of 76 cases, found the ratio to be 2 males to 3 females. They quote Broadbent, however, as finding the ratio to be 2 females to 1 male, and Gowers and Goodall give the proportion as 5 to 2. Koch,<sup>3</sup> in a total of 267 cases, found 100 males to 167 females. In my series of 125 cases I found a distinct neurotic lineal heredity in nearly twenty-five per cent., a fact of rather remarkable interest, in view of Koch's statement that heredity is not significant. Koch's observations, with reference to the etiological relationship of the seasons, are no less peculiar and at variance with nearly all other observers. He finds the disease most prevalent in winter, and states that twenty-two per cent. of his cases occurred in December. Morris J. Lewis,<sup>4</sup> who made a special study of the effects of climatic conditions and the influence of the seasons in the development of chorea, found in an analysis of 1383 cases, that the disease developed in the spring in 491, summer 382, autumn 204, and winter 306. My own observations are fairly in accord with these figures, and are further supported by Dana,<sup>5</sup> who found the largest number of cases occurring during the spring months.

The relationship of chorea and rheumatism, and of chorea and heart disease, is a subject of much importance in its bearings upon pathogenesis and treatment. While the exact relationship is still a matter of some doubt, there can be no question but that a certain etiological kinship does exist between the three, although chorea may unquestionably occur without any antecedent or personal rheumatism or cardiac disease. Sir Dyce Duckworth apparently believed to the contrary, for he is quoted by Sturgis<sup>6</sup> as teaching that rheumatism holds first place in the etiology of chorea, the latter being simply a manifestation of the rheumatic habit. Sturgis himself reports a rheu-

<sup>1</sup> *Gazette. Hebdom. du Bordeaux*, June, 1895.

<sup>2</sup> *American Journal of the Medical Sciences*, May, 1890.

<sup>3</sup> *Archiv f. klin. Med.*, Bd. 40, H. 506.

<sup>4</sup> *American Journal of the Medical Sciences*, September, 1890.

<sup>5</sup> *Archives of Pediatrics*, April, 1890.

<sup>6</sup> *American Journal of the Medical Sciences*, December, 1891.

matic element in twenty-five per cent. of the 100 cases analyzed by him. Dujardin Beaumetz<sup>1</sup> recognizes only two etiological factors in chorea, rheumatism and hysteria. (In only one of my cases was there any hysterical element. Racial peculiarities might, perhaps, partially explain this marked discrepancy, but it is too great to be accounted for solely on this ground.) Koch, in the series referred to, found a history of rheumatism in eighteen per cent., and of valvular heart disease in fourteen per cent. Walton and Vickery found in 36 cases no possible rheumatic or cardiac element of disease, but in the total of 76 cases, organic heart disease was found to the extent of 27.63 per cent., and rheumatism 23.68 per cent. Dana found a history of parental rheumatism in eight per cent., and of personal rheumatism in five per cent. in 130 cases. My own observations are more nearly in accord with Dana's figures, as I found a clear history of personal rheumatism in only about seven per cent., while, including both the organic and functional cases, I found decided disturbance of the heart's action in 19 cases, or about fifteen per cent.

The following conclusions seem legitimate:

1. Chorea is more common in females, in the proportion of two to one, than in males.
2. The disease is more prevalent in the spring months than at any other season of the year.
3. A neurotic heredity is of unquestionable importance as an etiological factor.
4. The disease seems to be especially liable to development in the unusually intelligent and precocious. Mental deterioration or perversion occurs only as a result (as a rule) of relapses of the disease.
5. Chorea may occur independently of either heart disease or rheumatism, but the frequency with which the three are found to be present in association is more than a coincidence. Further study is necessary before any positive conclusion can be reached as to the exact significance of this relationship.

#### SYSTEMIC INFECTION FROM GONORRHEA, WITH THE REPORT OF A FATAL CASE.

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CONSIDERABLE evidence is gradually accumulating concerning the liability to general constitutional infection from gonorrhea. So long ago as 1860, Barwell<sup>2</sup> enunciated the view that so-called gonorrheal rheumatism was a form or manifestation of pyemia, and this idea has continually

gained credence. For a long time, however, arthritis was the only extragenital complication of gonorrhea which appears to have received attention. Finally it was observed that iritis and capsulitis occasionally accompanied the arthritic complication, and then it was suspected that any of the serous membranes might become inflamed through the agency of the absorbed toxic products of a specific urethritis.

In 1876 a French writer, Marty,<sup>3</sup> after reviewing several cases of gonorrheal synovitis, which were accompanied by inflammation of other serous membranes, concluded that "Gonorrhea may be complicated with inflammation of all of the serous membranes, and may act in a direct way on each of them. Rheumatism is by no means a necessary middle condition between the specific lesion and the lesion of the serous membrane, although the coexistence of the two complications is most frequent."

The term "rheumatism" in this connection is unfortunate and misleading, for the process is essentially a septic one. During an attack of specific urethritis, gonococci or other pyogenic germs associated with them or their ptomaines may enter the circulation. Then by far the most common clinical manifestation of such an occurrence is an inflammation of the serous lining of one or more of the larger joints. But recent clinical and bacteriological evidence has shown that Marty was quite correct in assuming that other serous membranes might be attacked by the circulating poisons. On more rare occasions it seems probable that gonorrhea may give rise to a general septicemia, although some secondary local lesion will usually be found to predominate at the autopsy, if the case terminate fatally.

Gluzinski of Vienna<sup>4</sup> collected thirty-one cases of acute peri- and endocarditis which supervened in the course of gonorrhea. Not all of these were accompanied by an involvement of the joints, and some assumed the character of an acute infectious disease—as ulcerative endocarditis.

McDonnell<sup>5</sup> collected from the case-books of the Montreal General Hospital twenty-seven cases of gonorrheal arthritis, of which six were said to have shown signs of cardiac disease.

See<sup>6</sup> mentions two cases of gonorrheal pleurisy.

Dr. Panus<sup>7</sup> has reported an instance in which gonorrhea was followed by fever, intense headache, and ocular symptoms, which ended in optic

<sup>1</sup> *Archives Générales de Méd.*, 1876 (quoted by McDonnell).

<sup>2</sup> *British Medical Journal*, 1889.

<sup>3</sup> *Amer. Jour. Med. Sciences*, 1891.

<sup>4</sup> Ashurst, "Principles and Practice of Surgery," 1890.

<sup>5</sup> *La Semaine Médicale*, 1890.

<sup>6</sup> *Bull. Genl. de Thérap.*, March 15, 1894, p. 103.

<sup>7</sup> Barwell, "Diseases of the Joints," 1860 and 1881.

atrophy. He ascribed the trouble to meningitis of gonorrheal origin.

Leyden<sup>1</sup> has reported a fatal case of meningomyelitis, which apparently originated from an extensive gonorrheal cystitis.

The assumption that such cases might be merely coincidental has been set aside by the discovery of gonococci at the seat of the secondary lesion. In the *American Journal of Medical Science*, July, 1895, is an abstract of a paper recounting a case of specific epididymitis, which was followed by arthritis and fatal ulcerative endocarditis. Microscopic examination of fragments of the cardiac valves disclosed gonococci. Two similar cases have been noted in the *MEDICAL NEWS*.<sup>2</sup>

Many instances have been reported where the specific cocci have been found in the pus of complicating arthritis.<sup>3</sup> And, finally gonococci have been found in the blood of patients suffering from involvement of the joints.<sup>4</sup> It is very probable that the infection is usually of a mixed character.

In the text-books on genito-urinary diseases which I have at hand, such as Keyes, Bumstead and Taylor, and Durkee, little or no reference is made to the possibility of a general infection following gonorrhea. But the finding of the specific germs in various parts of the body suggests that such a result may occasionally be expected; and the very fact of the occurrence and frequency of gonorrheal bubo tends to show how often the poisons of "clap" start out to invade the system, and are only prevented from so doing, in the ordinary case, by the angry intervention of the inguinal glands. Often it is observed that specific urethritis is attended by a mild fever, which is undoubtedly due to a slight septicemia. Very recently I have had an instance of this kind in my own practice. A young man began to complain of headache and chills on the third day of the urethral discharge. His temperature, when first taken was 103°, and after this a mild pyrexia continued for nine days. The patient's family assumed that he had typhoid fever, an idea which, in deference to the wishes of the sufferer, I did not attempt to dispel, although there appeared no symptoms which could be attributed to any other origin than the inflamed urethra. There were also no signs of arthritis, pericarditis, or other complication.

I take it that such a condition as this might better bear the title of "gonorrheal fever," since it was distinctly a septic affair, than to lurk under

the name of "urethral fever," which still carries with it the vague idea of some obscure nervous influence.

If a thermometer be regularly employed when patients suffering from the first effects of specific urethritis present themselves for examination, it will usually be found that there is a slight elevation of temperature. This may not be more than 100°, but it serves to indicate a slight tendency toward septic absorption. At the same time, there will occasionally be heard the complaint of headache and a feeling of malaise. Such symptoms pass rapidly away; it is in the later stages of the disease that an elevation of temperature is of more consequence, when it usually precedes or attends the various local complications of an inflammatory character. It is at this time, too, that the distant serous membranes are most likely to be attacked.

Without having an opportunity to make an extensive examination of the literature on the subject, I have noted the reports of six fatal cases of gonorrheal origin—three from arthritis and endocarditis, and one from meningitis have been herein mentioned. Another death from gonorrheal endocarditis has been reported by DeFleury,<sup>5</sup> and recently, in the *MEDICAL NEWS*, Dr. Hawkins<sup>6</sup> has detailed a fatal case of gonorrheal rheumatism. It was unfortunate in this instance that the diagnosis was not confirmed by an autopsy, nor does it appear that a bacteriological examination completed the case.<sup>7</sup>

To this brief list I shall now add the following:

A. C., aged thirty-two, employed as a hotel clerk, was taken suddenly ill in the evening after attending to his usual work during the day. When I called to see the patient, on the following morning, the proprietor of the place told me that the man was a stranger in the city and had worked for him about six weeks, during which time he had attended strictly to business and had appeared to be in good health.

On first appearance, the case seemed like the onset of some acute infectious disease. The patient stated that on the previous day he had suffered slightly from headache, which increased toward evening. About midnight he had a severe chill, which was several times repeated. He had vomited freely, and complained of intense headache and "pain all over." His temperature was 105°; pulse 120; face deeply flushed, and conjunctivæ injected.

Inquiries regarding his family and personal history gave negative results. He had had the

<sup>1</sup> Editorial, *MEDICAL NEWS*, June 28, 1893.

<sup>2</sup> *MEDICAL NEWS*, Aug. 19, 1893, p. 217, and Dec. 22, 1894, p. 697.

<sup>3</sup> Senn, "Surgical Bacteriology," 1890.

<sup>4</sup> *Boston Med. and Surg. Journ.*, 1894.

<sup>5</sup> *Jour. med. de Bordeaux*, 1884.

<sup>6</sup> *MEDICAL NEWS*, June 13, 1896.

<sup>7</sup> Reference is chiefly made in this article to gonorrhea in the male subject. Severe cases of gonorrheal salpingitis, peritonitis, etc., are, of course, more common.

usual diseases of childhood; denied syphilis; acknowledged occasional alcoholic excesses; had never suffered from rheumatism in any form, and had recently been subjected to no unusual exposure or fatigue. His general physique was excellent; his weight about 170 pounds. A specimen of urine obtained at this time was normal in specific gravity and color, but contained a slight trace of albumin and a few pus-cells; the urethra had probably been washed by a more copious urination shortly before this was obtained.

During the first day of his illness, he developed a low type of delirium, from which he could, however, be easily aroused. When left alone he talked excitedly to himself, and was very restless, but made no attempt to leave his bed. This mental condition continued until coma supervened a few hours before his death, which occurred within four days of the time when he was first taken ill.

At times he complained of severe pain, but had difficulty in locating it; there seemed to exist a condition of general hyperesthesia, and he complained of soreness in various parts of the body. Pressure over the toes, ankle, and knee-joints elicited pain, but only on the last day of his illness was swelling detected. For the most part of the time he moved himself without difficulty, and in the earlier part of his attack there was no indication that the joints were especially involved. The temperature was irregular, varying from 99 to 105°; sweating was not marked; there were no pulmonary signs. The pupils remained contracted throughout; the expression was anxious rather than drowsy. Tongue red and glazed. The vomited matter, which at first was made up of bile-stained fluid, later consisted of mucus flecked with blood. There were no abdominal symptoms; the bowels were moved by calomel and an enema. By the third day, the entire body was dotted with purpuric spots, and it became evident that the patient was suffering from intense blood-poisoning, although no source of infection could be detected. The pulse was rapid and of high tension; for the first three days, the heart-sounds were clear and distinct, but on the fourth day became muffled; there were no murmurs.

After the purpuric eruption appeared, the patient grew rapidly weaker, and the delirium and jactitation were followed by coma and evidences of general nervous exhaustion.

Several diagnoses were suggested but none of them seemed quite satisfactory. The occurrence of intense headache and contracted pupils, with vomiting and general hyperesthesia, favored cerebrospinal fever. Since purpura and joint symptoms occasionally occur in this disease, such a view of the case seemed plausible. The severe onset and protean character determined against acute articular rheumatism; the involvement of the joints seemed to be secondary; there was be-

sides no sweating, nor did the one specimen of urine obtained, reveal an excess of urates or uric acid. And finally, the attack had assumed a resemblance to the few reported cases of acute purpura hemorrhagica. The blood in the vomited mucus showed that small hemorrhages had taken place in the gastric mucous membrane. Since no definite diagnosis could be arrived at, the case was treated as one of malignant septicemia; the autopsy showed that this conclusion was well founded, and the most probable origin of the blood sepsis was revealed. The following are the notes taken at the *post-mortem* table, condensed:

Body of man about thirty years old; height five feet ten inches; weight about 165 pounds. *Rigor mortis* in extremities (thirty hours after death). Purpuric spots scattered over entire body; left knee-joint seems to be slightly swollen; inguinal lymphatics can be felt slightly enlarged. On incision, the blood is found to be dark and fluid. No hemorrhages can be discovered in the muscular or areolar tissue. Pleuræ normal. Hypostatic congestion of both lungs. Pericardial fluid a little cloudy; quantity about two ounces; on the visceral layers of the pericardium is a white patch about the size of a dime; along the left coronary artery are a dozen punctate hemorrhages; there are no other signs of pericarditis. Cardiac muscle flabby and somewhat grayish; "chicken fat" clots; valves normal; two minute hemorrhages are found in the aortic lining, an inch from the valve. Stomach empty; vessels of mucous membrane deeply congested, and ecchymomata cover the posterior surface, but no free blood is found in the stomach or intestines, the latter appear to be in normal condition. Mesenteric glands slightly enlarged. Pancreas and liver normal. Spleen much enlarged, soft, and friable. On the capsule of the left kidney is a small blood clot, but otherwise these organs are normal in appearance. Ureters and bladder normal.

The cerebral and spinal meninges are deeply congested, but there are no inflammatory changes. No purulent foci found in any of the viscera. The synovial membranes of both knee-joints are bathed in their pus, but the quantity is not sufficient to flow from the joints when opened. A similar condition is found in the metatarsophalangeal joints of the great toes. A minute quantity of pus is also found in three out of six of the other toe-joints which are opened. The joints of the upper extremity are free from pus, but the synovial fluid of the elbows is cloudy.

After the death of the patient, among his effects was found a penis syringe, which showed signs of recent use, and also a broken package of absorbent cotton. Upon finding this clue, I opened the urethra and found behind a stricture of large caliber, in the middle of the spongy portion, a

drop or two of thin pus; from this point, evidences of inflammation were found as far back as the prostate gland. Cowper's glands were enlarged, and the duct of one was dilated and could be easily noted. The patient had been suffering from chronic posterior urethritis. Gonococci were present in the urethral pus. The body was, unfortunately, removed before I had an opportunity to return for a specimen of the pus in the joints, but I am quite well satisfied that the urethra was the original source of the infection. Had the pyarthrosis been primary symptoms referable to the joints, would have manifested themselves earlier. Certain it is, that a complete *post-mortem* examination in this case prevented the use of the word *idiopathic*, which has no proper place in the study of septic and pyemic diseases.

In concluding this report, I call to mind those lighthearted devotees of the bagnio, who scoff at a gonorrhea, and would as soon be so afflicted as suffer with a "cold," but then a man may "catch his death o' cold," and so too, as I have here shown, may he die of the "clap."

## CLINICAL LECTURE.

### SPINAL PARALYSIS.<sup>1</sup>

By CHARLES CARY, M.D.

OF BUFFALO, N. Y.;

PROFESSOR OF THERAPEUTICS, UNIVERSITY OF BUFFALO.

AN Italian laborer, aged forty, was injured two months ago by a tree falling across the small of his back. The accident did not disable him immediately, but within a few hours, absolute paralysis of the lower extremities set in, accompanied with anesthesia and with loss of control over the bladder and bowels. Subsequently, the paralysis was succeeded by paresis, and the muscular sense was so far restored that deep manipulation became perceptible.

Upon entering the hospital a few days ago, the patient complained of pain in the lumbar region and, on examination, posterior curvature was found. On questioning the patient, we learned that the pain ran down his legs, and that sensation in the lower extremities was still somewhat impaired. He controlled the urine and feces, and could walk fairly well.

It is a very important point to determine whether the patient could walk immediately after the accident or not. In this particular, there is a discrepancy between the history and the present statement of the patient. He says that he lay on the ground for about an hour after the accident, and was then lifted into a wagon and taken out of the woods. There was no involuntary evacuation of the bladder or bowels at that time, but the absence of these symptoms is not significant, since there may have been no pressure to call for a passage. The man was carried in a wagon some miles to Springfield, where he

arrived so cold and paralyzed that his friends at first thought he was dead. The truth or falsity of our understanding of the facts of the case will determine the correctness or incorrectness of our diagnosis.

The patient can now walk, as you see, and he crosses his legs and flexes them without trouble, though there may be some loss of power. He feels the prick of a pin in both legs, but he says it does not hurt, though I make quite a vigorous thrust. The same test applied to the arms elicits even less complaint of pain, so that we must admit that any apparent diminution of sensibility at present is peculiar to the individual. It not infrequently happens that men, accustomed to rough work and exposure, are incapable of appreciating as painful, slight injuries that would be intensely so to those of higher nervous organization. The patellar reflex is not quite so strong in the right leg as in the left, but there is no conspicuous deviation from the normal. Although the patient walks fairly well so far as mere ability to move is concerned, his gait is a little staggering and heavy, and he complains that the effort causes pain in the small of his back and running down the right leg. It hurts him when I press down on his shoulders. This fact should at once lead to the investigation of the condition of the spine, to determine if there is any yielding of the bony support that allows the pressure to be communicated to the cord. There is nothing very striking about the appearance of the spine, but there is a prominence of the lower dorsal and the upper one or two lumbar vertebral spinous processes. Pressure against the spine straightens the deformity somewhat, but it does not wholly disappear. The pain on downward pressure is located at this protuberance.

With a history as vague and contradictory as this, we can do little more than analyze the symptoms and statements of the patient and get at an approximate diagnosis. In the first place, we may be certain that the man received a severe injury in the region of the lower dorsal and upper lumbar vertebrae. As a result of the blow, the man was soon, though apparently not immediately, paralyzed. This paralysis may have been due to shock, for, in many spine and head injuries, the spinal or cerebral center is stunned so that a marked paralysis results, but disappears so soon that we may be sure that no absolute lesion of the centers was sustained. I have known such cases in which, merely as the result of shock, there was such profound paralysis that urine and feces were discharged at once. Shock of this sort, however—that is concussion—does not last long, while concussion of the cord is of much shorter duration than concussion of the brain. These cases of concussion of the cord have attained considerable notoriety as the results of railroad accidents. Serious chronic spinal lesions are often alleged to follow railroad injury, but these cases are mainly hoaxes, and recovery ensues soon after the obtaining of a verdict. I have no doubt, however, that shock of the spinal cord can and does occur.

The ride in the wagon would be sufficient to aggravate the symptoms of paralysis and shock. I do not question that the patient really was paralyzed, for he says that the lower part of his body and his legs seemed to be dead. What was probably the nature of the lesion? Strike

<sup>1</sup> Clinic at Buffalo General Hospital.

where you will, a blow to the living body, if it be sufficiently severe, is followed by the pouring out of serum, which becomes mixed with blood-cells if the injury is sufficient to rupture some minute vessel, and this may amount to an actual hemorrhage if the violence is great. The outpouring is not necessarily in the exact location of the blow upon the skin, but it must be in the line of violence to the tissues. In the present case, we have to think of an exudate occurring somewhere in the neighborhood of the spinal cord. So far as the paralytic symptoms are concerned, we may ignore the injury done to the bony parts and the ligaments outside the spinal canal. All such injuries would be diagnosed and treated on the general principles of surgical practice, but, except for concomitant shock, they would not be attended by any nervous symptoms. It is not possible at this late date to determine exactly what injury was done to the outside structures, but it appears from the contour of the spinal column that there may have been a fracture of the vertebrae. A displacement of the bony arch about the spinal cord would suffice for the establishment of a paralysis, but it would be relieved by the reduction of the dislocation and, on the other hand, there would not be recovery unless the deformity was corrected. The history of this case is entirely contrary to any such hypothesis. The paralysis did not come on instantly as if it were caused by the displacement of bone, it was not suddenly relieved by any manipulation, the recovery of function has not depended upon the reduction of fractured and displaced bone, but has progressed gradually. Moreover, the deformity persists, so that if there were a fracture of a vertebra at the time of the accident, it was not directly connected with the paralysis. Coincident with whatever damage to the vertebrae may be assumed, there was the outpouring into the spinal canal of some exudate, whose gradual but quite rapid accumulation led to a paralysis, which rapidly deepened, but did not occur at the moment of injury. The intensity and duration of a paralysis beginning in this way, depends on the size and location of the blood-clot and the rapidity of its resorption. As to the question between blood and serum, a serous exudate would be quite rapidly absorbed, while a blood-clot would probably first go on to organization and then be gradually, and perhaps, incompletely, reabsorbed. I learn that the man has never been any better since the injury than he is at present, so that the history points quite positively to the existence of a blood-clot. The condition is improving, and that means that the blood-clot is diminishing so that the prognosis is fairly good. While a massive clot is scarcely ever completely absorbed, a mixed hemorrhagic and serous exudation would account for the symptoms of the case and for the improvement, and would allow the hope of perfect recovery, ultimately.

A point to be considered more carefully, is the deviation of the spine. Is it old or new? Is it progressive, from which we would anticipate more serious disease which might later make actual bony pressure on the cord, or is it on the wane? I should rather not express a positive opinion on these questions until the opportunity had been afforded to watch the case for some time. I believe,

however, that, if there were an injury to the anterior portion of the spine, with serious lesion of the bodies of the vertebrae, the patient would throw his weight backward and rest his hands on his hips, so as to relieve the vertebrae of pressure as much as possible. On the other hand, if there were inflammation of the vertebral arches, he would walk, leaning forward so as to throw the weight of the body onto the sound anterior part of the vertebrae. As a matter of fact, the gait of the patient, though unsteady and assisted by the holding of the hands on the hips, is not characteristic of either form of vertebral disease. I think that the probability is in favor of the non-existence of serious disorganization of either arch or body, but of some little irritation posteriorly to the spinal canal. The evidence in favor of some displacement at the time of the accident, is confirmatory of this view of the case.

The treatment of the case deserves some attention. I think that if I had seen the man soon after the injury, I should have kept him flat on his back, so as to avoid all movement of the spine. After the first shock had subsided, I should have given him pretty active saline cathartics to deplete the system and reduce arterial tension, and thus tend to prevent the further outpouring of blood in the spinal canal. Later, there would have been an indication for the administration of iodids, in order to promote the absorption of whatever exudate had been thrown out. Extension of the spine to prevent deformity, if there really were fracture, would have been indicated and, at any rate, it would have served to keep the spine stationary. At first, the most appropriate method would have been by elevating the foot of the bed and applying counter-extension. I should still suggest potassium iodid to aid in the absorption of the exudate and, as long as pressure on the shoulders causes pain, I should advise that he be kept in bed. If the tenderness to pressure on the shoulders persisted after the time when the man should be walking about for the sake of necessary exercise, I should support the spine by means of a plaster jacket. I should, however, first test the usefulness of the jacket by extending the man in the perpendicular direction in order to learn if the projection of the spine was diminished. It is not uncommon to see men with such backs who have never met with any accident, and it may be that we are over-anxious about this man's spine. Even the skin over the projection is somewhat callous, and it may be that he has simply become bent from hard labor. The case, however, demands great care, and it is better to waste our time in watching a condition which has preceded the injury than to allow a recent deformity to become aggravated, for the development of a positive curvature of the spinal column would tend to increase the man's paresis, and would be very serious. I have nothing further to say regarding treatment, except that the diet should be liberal, and that various symptoms may arise requiring attention, which cannot be anticipated in detail.

**A Charter Revoked.**—The Illinois courts have received such evidences of fraud in the management of the Illinois Health University, located at Chicago, that they have decided to revoke its charter.

## CLINICAL MEMORANDA.

**REPORT OF A CASE OF IMPERFECT CLOSURE OF THE AURICULAR AND VENTRICULAR SEPTA, IN A MAN DEAD AT THE AGE OF FIFTY YEARS FROM ABSCCESS OF THE BRAIN.<sup>1</sup>**

By FREDERICK A. PACKARD, M.D.,  
OF PHILADELPHIA.

THE patient from whom this specimen was removed was admitted to the Episcopal Hospital on July 6, 1893.

He was an American, a sailor by occupation, and was engaged in his ordinary work at the onset of his last illness. His family history contains nothing of interest. He was always healthy, his only illness having been an attack of measles. He denied syphilitic infection, but has had gonorrhea. He remembers no injury to his head.

His last illness began suddenly, ten days before admission to the Hospital. He suddenly partially lost consciousness, and remained in a semi-conscious condition for about ten minutes. His friends told him later that while in this condition he had localized convulsion, involving the muscles of the right eye, the right side of the face, right side of neck, back, and chest, the right arm, and to a less extent of the right leg. He said that after regaining consciousness he had a numb feeling in the whole right side of the body. He was, however, able to walk, to raise the right arm, and to talk without difficulty. Four days later, he had another attack of the same character, in which he was totally unconscious. After this attack the right side felt very weak, though he thinks sensation was perfectly preserved. The arm and leg continued useful.

His condition on admission may be summarized as follows: He was a powerfully built, well-nourished man. Face bronzed, but more dusky than would be the case from exposure to the sun alone. Gums darker than normal. Lips very dark and apparently congested. Pupils equal and normal; no ptosis or other sign of interference with muscles of eye or lids. Face symmetrical. Tongue coated, but protruded in median line. Right arm and leg can be moved, but are distinctly feeble. Can talk and swallow perfectly. No lesion of ears. Examination of the heart showed slight enlargement (direction of enlargement not stated in the copy of the notes in my possession) and a blowing systolic murmur, most plainly heard at the apex, but also present distinctly over the body of the heart. The lungs were negative, save for the presence of a few subcrepitant râles on both sides posteriorly. Examination of the abdomen was negative. All of the tendon reflexes were found to be normal, save for slight increase of the knee-jerk and the presence of ankle-clonus on the right side. The temperature was normal, the pulse 80, respirations 24. Urine normal. The late Dr. Heyl, at that time ophthalmologist to the Hospital, kindly examined the eyes for me and reported: O. D., inner margin of disk obscured; tortuosity of retinal vessels; O. S., vessels tortuous; disk normal. There was no glandular enlargement, the teeth were normal, and there were no

skin lesions, save for a few blotchy areas on the upper third of the legs.

He was put to bed, an ice-cap was applied to the head, and he was given a five-grain dose of calomel, which was to be followed by the iodid of potash, in doses of ten grains, three times daily.

Nothing new developed until the night of July 8th. He then had a slight local convulsion, but the note of the next day says that "It did not bother him sufficiently to call the attention of the nurse to it." On the next day the patient seemed no worse.

At 6.15 A.M. on July 10th the patient commenced to be convulsed again. The right arm and leg began to jerk violently and rhythmically at intervals of two or three seconds. The alternate contraction and relaxation of the muscles closely resembled the effect produced by the slowly interrupted faradic current. The whole right side of the face and body was concerned in the convulsion, the muscles most involved being those of the right upper eyelid, the right side of the face, right side of neck, chest, and back, and the right arm. The right leg only occasionally contracted spasmodically. The note is not very clear as to the mental condition during the attack, but states that "there was no pain whatever," seeming, therefore, to corroborate my memory in regard to the more or less perfect retention of consciousness during the seizure. The attack lasted three-quarters of an hour. After the attack was past he complained of feeling tired, and it was noted that the right arm and leg were distinctly weaker. Careful examination showed no change in sensation.

On the next day (July 11th) he had no attack, but complained of a vague sensation in the left side of the head, that made him apprehensive of a seizure. This sensation was lessened by the application of an ice-bag.

On July 12th the patient was more stuporous, and was unable to raise the right arm, to articulate distinctly, or to put out his tongue. His temperature, which for the two preceding days ranged from 98.2 to 99.4°, rose, by 2 P.M., to 100°. A small quantity of urine was obtained by catheter, and found to be highly albuminous. He was put on the protoiodid of mercury on this day.

On the morning of July 13th the temperature was 99.4°, pulse 84, respirations 20. He was unable to move the right arm, and could not talk. Swallowing was quite a difficult act. Careful examination showed no other change in his condition. In the afternoon the temperature rose to 102.4° and his respirations became more labored.

On July 14th the morning temperature was 99°, pulse 90, respirations 22. He had a large number of involuntary stools since the day before. He was unable to take nourishment by the mouth, and was given nutrient enemata. Mercurial inunctions were instituted and the nape was well cupped. During the day Cheyne-Stokes breathing developed. In the evening the temperature rose to 102.6°, pulse 104, respirations 26.

During the night and the next day the patient remained unconscious, but no convulsions were present (nor had he had any since July 10th). Death occurred at 5 P.M.

The diagnosis made before death was tumor of the brain of latent course, with sudden accession of symptoms due

<sup>1</sup> Read before the College of Physicians of Philadelphia, May 6, 1896.

to hemorrhage within its substance. The location of the tumor was supposed to be in the subcortical region on the left side of the brain, the destruction of brain-tissue being probably greatest near the origin of the internal capsule, but it was supposed that the hemorrhage was at first most marked near the cortical side of the tumor, producing irritation of the cortex and convulsive seizures. How erroneous the diagnosis was can be seen by the report of the necropsy. While the possibility of cerebral abscess was, of course, considered, the absence of middle-ear disease, of trauma, of primary focus of pus, caused that, the easiest explanation of the symptoms and course of his illness to be rejected.

*Post-mortem* examination was made on the day after death, and the following notes were dictated. Well-nourished body; skin dark. There is some dense edema of the legs, and on the shins a copper-colored, diffuse eruption, with small superficial scars.

Scalp and calvarium are normal; also bone, dura, and sinuses at base of skull. Dura mater is somewhat adherent to convexity of cerebral hemispheres. Beneath the pia arachnoid covering the lower surface of the cerebellum there is a diffuse movable collection of about a dram of greenish-yellow pus. Arachnoid in that situation is opaque, thickened, and wrinkled. Base of brain is normal, except for some overfulness of the vessels. Island of Reil is normal on both sides. Vessels of pia arachnoid over convexity generally are filled with dark blood. Over parietal lobe of left side, pia arachnoid is adherent to brain substance. On handling the brain a rupture took place just behind the supramarginal gyrus, and about an ounce of fetid, greenish, thick pus escaped. The left lateral ventricle filled with greenish pus, and the ependyma is thickened, granular, dark, and almost gangrenous in appearance. The surface of the basal nuclei was softened. On the right side the lateral ventricle and its nuclei were normal. In the third ventricle there was some greenish pus similar to that in the left lateral ventricle, but the ependyma looked quite normal. The iter contained a little pus, as did also the fourth ventricle. The wall of the latter was granular and softened. On section of the hemisphere it was found that beneath the supramarginal gyrus of the left side there was a walnut-sized cavity, with black, gangrenous walls, just beneath the cortex and extending inward and downward to open into the lateral ventricle, and also extending forward and downward into the basal nuclei. On section of the basal nuclei of the left side, it was found that the abscess cavity had encroached upon the lenticular nucleus, the whole lower two-thirds of which were gangrenous. All of the basal nuclei on the left side were distinctly softened. Organs of abdomen are in normal position. Pleural cavities are normal and free from fluid and adhesions. Pericardium is normal.

Primary section of the heart shows that all chambers are filled with clots. In all chambers there is much chicken-fat and currant-jelly clot, but there is also a small quantity of adherent *ante-mortem* clot. Heart is globular in shape. Apex is made up of right ventricle. Large proportion of the total bulk of the heart is composed of

the right auricle. Coronary arteries are very prominent. Weight of heart, when freed from clots, is fifteen ounces. Muscle-substance of all chambers is of a deep brown. Right auricle is tremendously dilated. Appendix of auricle is also much enlarged. Thickness of wall of right auricle at thickest part is about 2 mm. Endocardium of auricle is smooth. Foramen ovale patulous, admitting the end of a lead-pencil. Immediately below the foramen ovale there is a deficiency in the interauricular septum, leaving an arched entrance from the right to the left auricle, that permits of the insertion of the index-, middle-, and ring-fingers. The arch is evidently composed of muscle-fiber; its edge is smooth and rounded, and the surrounding endocardium is thin, clear, and otherwise normal in appearance. The orifice in the septum is bounded below by the lines of attachment of the anterior mitral and posterior tricuspid leaflets. On looking into the right auricle from above, one sees the auricular surfaces of the mitral and tricuspid valve leaflets, and also through the deficiency the posterior wall of the left auricle. The left auricle is very much smaller than the right, being even somewhat smaller than normal. On looking into it from above, one sees the patulous foramen ovale; below this the arching border of the interauricular opening and the interior of both right and left ventricles is plainly to be seen. The auricular appendage communicates with the cavity of the auricle by an orifice that just engages the tip of the middle finger. The right ventricle is much dilated and its wall hypertrophied. The muscle-substance is somewhat darker than normal, but is otherwise of normal appearance. The thickness of the wall is 13 mm. Columnæ cornæ are very thick and firm. Two large papillary muscles spring from the septum, and a diminutive one arises from the anterior wall. The tricuspid orifice readily admits four fingers. Valve leaflets of tricuspid normal, except for their extraordinary largeness. The chordæ tendineæ of the tricuspid valve are remarkably numerous and very thick. The undefended space is closed merely by the posterior tricuspid and anterior mitral leaflets. The finger readily passes from the channel of the tricuspid into that formed by the mitral leaflets, and the finger so passed through the interventricular deficiency is plainly seen on looking down into the auricles. The pulmonary artery cusps are very large, but are otherwise normal in appearance. The pulmonary orifice measures 10 cm. 1 mm. in circumference. The aortic orifice measures 7 cm. 6 mm. in circumference. The cavity of the left ventricle is relatively small—about two-thirds that of the right ventricle; its wall measures 7 mm. in thickness. Endocardium appears to be normal. There is but little development of the columnæ cornæ. There is only one well-formed papillary muscle, which springs from the posterior wall, is short and very thick. This sends three short, thick chordæ tendineæ to the posterior half of the anterior mitral leaflet and two to the posterior leaflet. The other chordæ to the latter spring from two rudimentary papillary muscles that arise from the posterior wall. The anterior portion of the anterior mitral leaflet stretches across from the chordæ already mentioned as arising from the papillary muscle, and is pushed through

the deficiency in the septum in such a way that upon looking at the edge of the deficiency from the right ventricle, there are seen several short chordæ tendineæ rising from the right side and edge of the septal border and running through the orifice to join the anterior portion of the anterior mitral leaflet. Both of the mitral leaflets are somewhat opaque. The aortic orifice is guarded by three cusps, all of which are freely perforated near their free borders. The cusps otherwise show nothing out of the way. The coronary arteries spring from the root of the aorta in the normal position, the orifices being very large. At the root of the aorta there are a few scattered patches of yellowish-white thickening. The importance of a thorough examination of the arch of the aorta and its branches and of the pulmonary artery was not realized until after the heart had been taken away for more careful study, when it was too late to make a further examination.


Sections of the vermiform appendix show a marked amount of submucous round-celled infiltration generally, while in one area the center is necrotic, and evidently has proceeded to abscess-formation. The kidneys show diffuse round-celled infiltration of the interstitial tissue.

To first dispose of the cerebral abscess, it is possible that it may have been due to embolism from the vermiform process, although it seems an unlikely situation for a solitary embolic manifestation from disease of that portion of the intestinal tract. There was no other possible source of origin for the pus. From the character of the collection in the brain, it was thought to be probably due to disease of the middle ear, but careful examination of the base, and especially of the petrous bone, showed no evidence of disease. It is possibly only a coincidence, but is at least a remarkable fact, that at the last meeting of the American Pediatric Society three cases of abscess of the brain occurring in the subjects of congenital heart disease were mentioned. One case was reported by Acker of Washington and one by Jacobi of New York, while the subject of the present article was referred to by the writer in the discussion upon these two cases.

The lesion of the heart in this case resembles, in most respects, the not extremely unusual one of patulous foramen ovale, deficiency of the auricular septum, and deficiency of the ventricular septum at the undefended space. The most remarkable features are the large size of the pulmonary artery as compared with the aorta, and the peculiar arrangement of the anterior mitral leaflet, whereby it receives most of its chordæ tendineæ from the right edge of the border of the septal orifice.

While the dissection of the distal portions of the great vessels was not carried out, it would seem that the specimen represents a failure of development—an agenesis—pure and simple, rather than a permanent defect produced by inflammatory lesion preventing the normal separation of the cavities. It is impossible to see why such extensive failure of achievement of this separation should occur where a much smaller amount of communication between the cavities has been ordinarily produced by even extreme stenosis of one of the arterial orifices of the heart. It seems that the deformities present in this case can be readily explained by a failure of the commissural band to

form by fusion of the median parts of the auriculo-ventricular lips of Lindes, with simultaneous failure in development of the primitive interauricular septum and of the median portion of the interventricular septum. The ventricular septum is completed toward the end of the eighth week; the auricular septum forms only after the completion of the separation of the ventricles and that of the arterial bulb. The formation of the commissural band also occurs after the completion of the latter. It can, therefore, be seen that the time at which this anomaly was produced was just prior to the completion of the interventricular septum, and at a time when the primitive auricular septum was simply represented by a ridge coursing over the ceiling of the common auricle.

The failure of development of the commissural band would account for the peculiar complete absence of separation between the anterior mitral and posterior tricuspid leaflets. Rokitsky<sup>1</sup> has likened the auricular canal after the formation of the auriculo-ventricular lips to a figure shaped thus: , the long horizontal arm of which represents the space between the surfaces of the auriculo-ventricular lips, the shorter perpendicular arms representing the future auriculo-ventricular orifices.

According to Moussons,<sup>2</sup> the relations of the auriculo-ventricular valve leaflets in cases of failure of development of the interauricular septum may fall into one of three categories: (1) The auriculo-ventricular valves remain in relation with the inferior border of the incomplete interauricular septum; (2) they may be inserted upon the superior border of an incomplete interventricular septum; or (3) they are only attached to the commissural band, which has maintained its independence. In the present case the anterior mitral leaflet is divided into two portions—an anterior, springing from the common auriculo-ventricular border and with chordæ tendineæ, which arise from the right side of the interventricular septum and pass through the deficiency therein, and a posterior portion, which arises from the auriculo-ventricular border and has chordæ tendineæ springing from the poorly differentiated posterior papillary muscle. Between these two portions there is a cleft corresponding to the plane of the incomplete septa and, therefore, to the position that should be occupied by the commissural band. The small size of the left ventricle in the present case is very striking, the septum protruding into its cavity, i.e., the septal surface viewed from the left ventricle, is convex. Upon the left ventricular surface of the septum there is a thickened layer of muscle-fiber, looking not unlike a flattened and poorly developed papillary muscle. Taking into account the position of the septum, toward the left side of the heart, this flattened, aborted papillary muscle on its surface, and the origin of the anterior portion of the cleft anterior mitral leaflet from its upper and uncompleted portion, it seems not unreasonable to attribute this malposition of the leaflet and the small size of the aorta (as compared with the pulmonary artery), with the lessened capacity of the left ventricle to the origin of the ventricular septum from a point too far toward the left, rather than to con-

<sup>1</sup> "Die Defecte der Scheidewände des Herzens," p. 68.

<sup>2</sup> "Maladies Congénitales du Cœur."

sider the small size of the left ventricle as dependent upon the small dimensions of its arterial trunk. In view of the absence of careful study of the subsequent character and the main divisions of the aorta and pulmonary artery, it is impossible to deny a transposition of the divisions of the arterial bulb as the causal factor in the case, but the latter explanation seems to the writer to be less satisfactory than does the former.

In regard to the duration of life in lesions of this character, but little need be said, inasmuch as the principal defect (deficiency in the formation of the auricular septum) is the congenital lesion that is least incompatible with life, save in cases where there is simple failure in the complete development of the interventricular septum at the undefended space. That auricular defect can exist for many years, is seen by the following brief summary of facts:

Peacock<sup>1</sup> says: "Where there is only some slight irregularity in the development of the heart, so that small openings exist in the septa of the auricles or ventricles, the defect is of very little importance; indeed, it is by no means uncommon for such openings to be found in the hearts of persons who have died at advanced periods of life, and have never presented any signs of cardiac disease. On the other hand, where the arrest in the development of the heart is more extensive, and is combined with some form of obstruction, it becomes a source of serious suffering, and the duration of life is limited to a comparatively short period." He gives no definite data as to the length of life of cases with marked septal deficiency, and it would seem that in the above sentence he refers rather to the cases of slight communication between the cavities, as in the case of unclosed, undefended space or patulous foramen ovale, than to such marked deficiency of separation as was present in the specimen from my case.

Moussons<sup>2</sup> groups all cases from a prognostic point of view into eleven classes, of which but one—composed of malformations of the interauricular septum—in any way corresponds to this specimen. In this group he collects 19 cases, of which 5 died between the ages of thirteen and twenty years; 6 between twenty and twenty-five years; 5 between twenty-five and forty years; and 3 between forty and fifty years. In this table no statement is made as to the size of the orifice between the auricles, a factor that cannot fail to have much bearing upon longevity. In a heart wherein the primary auricular septum was completely developed, with simply a cribriform arrangement of this, due to failure of development of the secondary interauricular septum, there might be but little commingling of the blood-stream or alteration in the dynamics of the heart.

Rokitansky<sup>3</sup> relates details of twenty cases of defect of the interauricular septum of greater or less degree. Of these twenty cases, two newborn and eighteen adults were the subjects of the anomaly. The ages of the adults varied from nineteen to sixty years. As many of these present marked points of similarity to the present case, a

brief account of some of them may be not without interest. In Case I, a man dying at the age of fifty-five years with a variety of lesions, including tuberculosis of the lungs, an apparent internal pachymeningitis, and a variety of other lesions unconnected with the cardiac anomaly, there was an interauricular communication, having a diameter of 28 mm., and due to defect in the primary septum. Case II was an adult (age not stated), whose heart presented a rudimentary interauricular septum, a closed foramen ovale, and a split aortic leaflet of the mitral (as in my case). The interauricular orifice measured 30 mm. in diameter. The man had in addition pericarditis, purulent exudate in the right pleural cavity, ascites, and anasarca. A drawing of the auricular defect in this case<sup>4</sup> fairly represents the appearance in my own case, save for the closure of the foramen ovale. Case III died of typhus at the age of twenty-three years, the heart showing an orifice between the auricles that measured 18 by 28 mm., and a split anterior mitral leaflet. Case VI concerned a sixty-year-old man, whose body showed, in addition to the cardiac anomaly, the remains of an encephalitis. The interauricular communication measured 9 mm. by 5 mm. The case is mentioned here because of the apparent similarity between this and the writer's specimen in regard to the peculiar connections of the aortic leaflet of the mitral valve with the defective septum ventriculorum. Case VIII died at the age of fifty years, and autopsy revealed, in addition to many small hemorrhagic cerebral lesions and pulmonary artery thrombosis, an interauricular defect measuring 57 mm. in diameter. Case X died at the age of forty-two years, and possessed an interauricular defect that measured 40 mm. in diameter. The case died with universal edema, but from the data given it is impossible to determine the influence of the cardiac defect upon the length of life. The other cases either died at a much earlier age or had but little in common with my case from an anatomical point of view.

The facts in my case may be summarized as follows: Clinically, the case is of interest from the fact that the patient apparently suffered so little from a marked cardiac defect that he was able to perform the arduous duties of a sailor until the onset of a presumably independent cerebral lesion, eighteen days before his death; from the occurrence of a cerebral abscess, the only discoverable source of origin for which was the inflamed vermiform appendix. Pathologically, the interest in the case lies in the great lack of development of the septum atriorum, the smallness of the left and large development of the right side of the heart, and the peculiar arrangement of the anterior mitral leaflet and of the chordæ tendineæ of the anterior portion thereof.

#### A CASE OF ANGIO-NEUROTIC EDEMA.

BY NORMAN C. YARIAN, M.D.,

OF CLEVELAND, O.;

HOUSE PHYSICIAN TO CLEVELAND GENERAL HOSPITAL.

ON May 1, 1895, I was called to see Mrs. K., who was suffering from a severe "sick spell," as she termed her periodical attacks. I found her vomiting and retch-

<sup>1</sup> "On Malformations, etc., of the Heart," p. 129.

<sup>2</sup> *Loc. cit.*, p. 226.

<sup>3</sup> *Loc. cit.*, pp. 34 to 53.

<sup>4</sup> *Loc. cit.*, p. 37.

ing in the most violent manner, and doubled up on the floor from severe pain, which she located in the epigastric region. The vomited matter was mostly biliary. Her hands and face were very edematous; her pulse weak and rapid, while her moans were audible at some distance.

The picture was one of seeming great agony, and yet I felt that there was a nervous element in her trouble. I knew of her having had the attacks from childhood, and being unable to make a diagnosis at that time, I treated the case symptomatically.

My prescription was morphin  $\frac{1}{8}$  grain, atropin  $\frac{1}{100}$  hypodermatically, with bismuth subnitrate, ipecac, and calomel in small doses by mouth, followed after vomiting had ceased by moderate doses of calomel, to unload the bowels and stimulate the kidneys to more active secretion, and sodium bicarb. She soon experienced relief.

I was called at several subsequent attacks and always gave the hypodermic, but sometimes changed the other prescriptions. Thinking the trouble at least partially a nervous one, I prescribed strychnia  $\frac{1}{10}$  grain three times a day between the attacks, followed by a general tonic of nux vomica, gentian, and cascara for her constipated habit. This medication seemed to make the attacks lighter and less frequent while taking it, but had no lasting effect. Nor did a course of syrup hypophos. co. give any permanent relief.

Her history, both personal and family, is of interest, showing the hereditary and nervous nature of the disease.

*History.*—Mrs. K., aged fifty-four, American, married, two children, both girls; oldest died at age of twenty-one from tuberculosis; showed no symptoms of mother's disease except a very irritable disposition. Other daughter living, aged twenty-five, is the mother of a healthy daughter. Neither mother nor child have shown symptoms of the disease except the same irritable dispositions.

Mrs. K. relates that while she was still a child, her mother noticed periodical attacks of blanching of the surface of the skin and vomiting. She cannot remember a time when she has not suffered from these periodical attacks of edema, following by gastralgia and vomiting.

The attacks begin by a general feeling of malaise or pain, soon some part of the body, usually the hands, face, feet, arms, shoulders, or chest, will begin to swell and become very edematous. Often, simultaneously with the edema, occur purple rings upon the chest, neck, arm, and hypogastric region. These, however, more often occur just as the edema subsides. Mental emotion, particularly anger, is capable of precipitating an attack, and they often occur with great suddenness. Her appetite is often ravenous and erratic just before an attack, but nothing she eats seems to influence the attack or precipitate it. From twenty-four hours to two days after the swelling begins she is taken with a severe distinct pain, usually in region of the stomach, but sometimes in the bowels. She describes it as being very severe, even terrible and prostrating. This is followed by nausea and vomiting, with severe retching. After freely vomiting, her pain and edema leave, an attack in the morning often failing to incapacitate her for labor in the afternoon.

The attacks show a marked periodicity, occurring on

an average of once in two weeks since her child-bearing period, but previously every week for several weeks, then skipping several, nine weeks being the longest period of immunity which she has ever enjoyed. The edema sometimes occurs without the vomiting and pain. The attacks are always more severe when occurring at a menstrual period, and they were also more severe during her menopause.

The patient had the attacks regularly during both gestations.

*Family History.*—Mother had same attacks from childhood, but not so severe. Never had them during periods of gestation. Died at the age of sixty-three years of dropsy. (Could not learn the cause.) After menopause, she suffered from purpura, and her attacks grew lighter, occurring every two to six weeks. Patient's two brothers and one sister not affected. Uncle on mother's side had same attacks. He looked like his mother and grandfather. Died at age of forty-two of edema of glottis. One other uncle and aunt well. Deceased left one child, a girl, who has periodical edema, but no gastralgia nor vomiting; also one boy who had edema, but died at age of seven years of scarlatina. Grandfather (on mother's side) and some of his brothers had same periodical edema, but lacked the pain and vomiting. Great-grandfather (on mother's side) had same edema, but none of the other symptoms. The attacks have grown worse from generation to generation up to the last two, which have so far proven immune.

There is a marked nervous element in the attacks as shown by the sudden oncome and also sudden disappearance. Their effect upon her general health and strength is very slight, and will perhaps only slightly influence longevity.

No physician has ever been able to influence the disease in any of the successive generations, except for a very brief time.

## NEW APPARATUS.

### A SIMPLE AND EFFECTIVE SPLINT FOR THE TREATMENT OF HIP DISEASE.

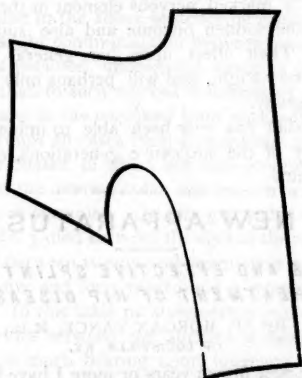
By AP. MORGAN VANCE, M.D.,  
OF LOUISVILLE, KY.

FOR the past fifteen years or more I have been using a short fixation splint in the treatment of hip disease, made of the fine saddle skirt leather, molded over the patient and made removable by lacing, crutches with high shoe being necessary for locomotion. The advantages claimed for this splint were its lightness, cleanliness, durability, and the fact of its easy removal; besides, it could be prepared without the aid of an instrument-maker, and could be worn effectively without the constant care of the surgeon. Therefore it served an excellent purpose in those cases which came from a distance for treatment. The great disadvantage in the use of this very simple apparatus was found to be the tendency on the part of the little patients to lay aside the crutches in the excitement of play and walk on the diseased limb, notwithstanding the hampering influence of the high shoe on the affected side.

My friend Dr. J. B. Bullitt, of this city, suggested to me the trial of the splint used by Lorenz, of Vienna, which is a plaster-of-Paris splint, reaching from the umbilicus to just above the ankle, combined with a stirrup of strap-iron under the foot, a high shoe on the good foot, the weight of the body resting on the ischium, where the splint was furnished with a good pad. The idea which I had entertained for a long time of making my splint a walking apparatus was stimulated by a trial of the plaster-of-Paris splint of Lorenz, and I made the effort in November of 1895. Instead of the strap-iron as used by Lorenz for the stirrup, I used a small, solid brass rod, a material I had employed for a long time for knee-splints and paralytic apparatus. The very satisfactory use of the apparatus resulting from this first experiment, along with some dozen other cases to which I have since applied it, influences me to give it to my professional brethren, with a short description of the method of its construction, illustrated as best I can with cuts.

The original leather fixation splint referred to is made as follows: If there is deformity present, or an acute exacerbation in the joint, a weight and pulley are applied and the child kept in bed for a few days or weeks, as may be required; then the piece of leather is cut from a side of the best saddle skirting, after a pattern of paper which has previously been fitted to the patient. The shape of this is represented in the outline drawn in Fig. 1. When this is molded—which is made very

FIG. 1.



easy by immersing the leather in hot water until well wetted through, the temperature of the water regulating the stiffness of the splint when dry, a few degrees below boiling making it about right, an ordinary roller, or better an elastic bandage, is used to mold it to the patient—it extends from the umbilicus to the knee, the leather being so cut and placed as to bring the lacing of the thigh and pelvic portions in front. Two nicely trimmed tongues of the same leather are cut from the flank part and riveted on with a tubular riveting machine, large shoe-hooks having first been placed along the outer edge of the part to be laced. A special tool is required for this; or the lacing may be done through simple holes made with the ordinary leather- or belt-punch. It is best to put the hair or smooth side of the leather next the skin;

then, ordinarily, nothing need be worn between the splint and the body. While this leather portion is allowed to set, not to dry, an outline drawing is made of the splint in position and the leg below, care being taken to locate on the paper the upper edge of the splint, the ischium, lower edge of the splint, bottom of heel, and a point  $2\frac{1}{4}$  inches below the heel. This drawing will be needed as a working pattern to be used in properly bending the brass rod, which will make up the balance of the apparatus. A solid brass rod from one-quarter to three-eighths of an inch in diameter, the length necessary being determined by measurements of the special pattern, is bent so as to be

FIG. 2.



applied to the splint of leather in such a way as to extend from the front of the pelvic part of the splint down the outer side of the limb, under the foot, up the inner side of the limb to the ischium, around to the outer side of the splint, to meet again about the trochanteric region, up the outside of the pelvic part, and back to the middle of the pelvic portion behind. This brass frame is then fastened to the leather by leather battens riveted through and through with tubular rivets, a smooth pad of leather

being fitted over the rod and leather so as to form a firm rest for the seat-bone. A leather band below to fix the leg, and a leather sole with arrangement for attaching extension, if needed, complete the apparatus, the whole being covered with a thick coat of shellac if the child is in the habit of wetting the bed.

Fig. 2 shows the splint complete. The great durability and firmness of this splint, along with the fact that it is easy of removal and that it cannot be improperly applied, coupled with the fact that it can be made by the surgeon himself, and fills all the mechanical indications in the treatment of this most troublesome disease, make it, in my humble opinion, one of the best mechanical contrivances yet proposed. The comfort with which the little patients are immediately able to walk about, and the simplicity of its construction, with its cheapness, will recommend it for a trial.

## MEDICAL PROGRESS.

**Intestinal Sand and Muco-membranous Enteritis.**—In two cases mentioned by MATHIEN and RICHARD (*Gaz. hebdom. de Méd. et de Chirurg.*, May 28, 1896), the feces were mixed with grains of yellow sand, one-quarter to one-half millimeter in diameter. In one case, the grains were often agglutinated, and formed masses much resembling white pepper kernels. In their composition, the salts of lime predominated, and in this they resembled the calculi sometimes found in the appendix, intestine, nasal passages, bronchi, etc. In both cases mucoenteritis was present, which the authors looked upon as the cause of the concretions, as the membranes contained microscopical crystals of calcium phosphate. The abnormal deposit of these crystals in the mucous membrane would, it was thought, cause mucoenteritis, and the stasis due to constipation, would allow the formation of the palpable grains of sand.

Others have mentioned the coexistence of mucoenteritis and intestinal calculi.

**Removal of One-half of the Kidney for Tuberculosis; Favorable Prognosis in Renal Malignant Disease.**—How important has become the application of surgery to the kidney, is shown by the fact that a single operator, J. ISRAEL of Berlin, is able to report (*Deut. med. Woch.*, May 28, 1896) 126 cases so treated by himself. Eleven times the kidney was extirpated on account of tubercular disease. In a twelfth case, the lesions were situated so evidently in one end of the organ that Israel decided to remove only the upper half of it. Hemorrhage was avoided by digital compression of the renal artery during the cutting away of the diseased portion. Then a compress was held against the cut surface for some minutes; upon its removal there was no bleeding, but for safety, a piece of gauze was stitched by catgut against the cut surface. Recovery was prompt and complete, and the patient has remained in good health for over a year.

This operation is recommended only in exceptional cases, as tubercles too small to be observed at the operation usually extend beyond the area of the gross lesion.

Another encouraging feature of this report is the chapter on malignant tumors of the kidney. There were seventeen such cases—six carcinomata; ten sarcomata, and one so-called struma renalis. Complete nephrectomy was performed in each case. Two patients died from operation; one a year later, of acute peritonitis, without recurrence of the cancer, and six were well at the time of report, no recurrence having manifested itself in periods ranging from fifteen months to nine years.

**Chlorosis No Contraindication for Marriage.**—The question which is often put to the physician as to whether a chlorotic girl ought to marry, has been fully discussed in a monograph by GROSSET (*Thèse de Paris*, Steinhil, 1896). His conclusions are:

1. The physical and spiritual excitement which marriage offers a chlorotic girl can have only a favorable effect upon her disease.

2. The sterility of chlorosis is only a temporary one in most cases, the rare instances of infantile genitals being excepted.

3. Chlorosis does not predispose to abortion.

4. The children of a chlorotic woman are likely to be chlorotic, but seem to show little tendency to become tuberculous.

Chlorosis, therefore, is no contraindication for marriage.

**Tumor of Mesentery; Tubercular.**—In the *Deut. med. Woch.*, June 11, 1896, GRUNBERG mentions a rare case of tuberculosis isolated in the mesenteric glands, and resulting in an abscess holding about two pints, which formed a freely movable tumor in the right side of the abdomen, the site of which was correctly diagnosed, but whose nature was not suspected until it was ruptured in the attempt to shell it out of the mesentery. The patient was an eight-year-old girl, with no previous illness except a diarrhea of short duration three months previous to the appearance of the tumors. At the autopsy, three days after operation, other mesenteric glands were found tubercular, but there were no other traces of tubercle organ.

**Technic of Esophagoscopy.**—V. HOCKER (*Wiener klin. Wochenschr.*, 1896, Nos. 6 and 7) uses a Mikulicz-Leiter instrument with a small incandescent light. The tubes have a caliber of from 11 to 14 mm., and are 19, 30, 40, and 45 cm. long, corresponding to the usual situations of cancer at the beginning of the esophagus bifurcation of the trachea, lower end of esophagus, and cardiac end of stomach. Hocker begins the passage of the instrument with the patient in a sitting posture, but allows him gradually to recline on his side with his head over the edge of the table. Cocain in the pharynx is better than morphin, and controls the flow of saliva. In two hundred cases no accident has resulted; in two cases, the instrument could not be passed.

**The Mortality After Removal of the Scapula.**—SCHULTZ has made a study of the 214 cases recorded in medical literature in which the whole scapula was removed, either alone or with the arm and part of the clavicle. The results as published in the *Deut. Zst. f. Chirurgie*, vol. xliii, p. 442, are worth knowing.

## REMOVAL OF SCAPULA ALONE.

	Cause.	No. of Cases.	Mortality, Per cent.
Before 1875.....	Malignancy.	23	17.39
After ".....	"	28	7.14
Before ".....	Caries, etc.	8	12.50
After ".....	"	14	.....
.....	Injury.	17	52.94

## REMOVAL OF WHOLE UPPER EXTREMITY.

	Cause.	No. of Cases.	Mortality, Per cent.
Before 1875.....	Malignancy.	26	19.23
After ".....	"	69	13.04
.....	Caries, etc.	7	.....
.....	Injury.	22	36.36

From these tables it is evident that the prognosis after this formidable-appearing operation is much better than might be expected. The percentages of recurrence after operation for malignant tumors are less satisfactory. These are given as 35 and 28 per cent. before and since 1875, where the whole shoulder was removed, and 39 and 19 per cent. in those cases where the scapula alone was removed, before and since 1875.

## THERAPEUTIC NOTES.

**Hemol Bromid.**—In order to avoid the unpleasant after-effects of the inorganic bromids, KOBERT (*Therapeutische Wochenschrift*, 1896, No. 17, p. 400) has been making trial of an organic bromid which has no injurious effect upon either the blood or digestion. It contains only 2.7 per cent. of bromin, as against 67 per cent. which bromid of potassium contains. But only a small portion of the bromin contained in the latter salt exerts any action in the body.

Holst used bromid of hemol in fifty cases of nervous disease. If a rapid effect was looked for, two grams (thirty grains) were given three times a day. One-half or one-third of this dose was employed for a calming effect. In epilepsy and hysteria, he obtained no good results where the inorganic bromids have shown themselves efficacious. In insomnia, the results were equal to sodium bromid, without any unpleasant sequelæ.

The conclusion is that bromid of hemol is not capable of replacing inorganic bromids where a rapid effect is desired. It is indicated, however, in cases where the sedative and long-continued action of bromin is sought for.

**Abortion from Guaiacol.**—A woman twenty-nine years old, and three months pregnant, was given (PETRASKO, *Pesther med. Chir. Presse*, 1896, No. 5) at morning and noon three-quarter grain of guaiacol on account of an affection of the left pulmonary apex. On the sixth day, when about twelve grains had been taken, the patient aborted. The physician could find no other reason for the abortion except the guaiacol.

**Influence of Somatose on Milk Secretion.**—The diminution or disappearance of the mother's milk in a few months or perhaps in only a few weeks after her child is born, is a source of annoyance and pain to the mother, and may prove fatal to the baby. It is no wonder then that DREWS of Hamburg, feels happy over the results which he has been able to obtain with somatose, and which he describes in the *Centralblatt f. Innere Medizin*, June 6, 1896. He has given the drug in teaspoonful doses, three or four times a day, to twenty-five women who experienced premature exhaustion of breast milk, caused by anemia or by loss of blood during pregnancy or labor, or by debility from frequently repeated parturition, or by intercurrent diseases. In every case the secretion of milk became sufficient for the baby, and the pains in back and breast disappeared.

The results could not be attributed to anything else than the somatose. The diet was not an especial one. Many of the patients had been treated with tonics and other remedies without avail. It was further shown that when the somatose was cut off, in a very short time the milk began to diminish, and the pains returned, even though the appetite and general health were in no way affected.

**Arsenic by the Rectum.**—VINAY (*Lyon Méd.*, April 12, 1896) prefers to administer arsenic by rectal injection, for the reason that despite every precaution, subcutaneous injections are apt to be followed by abscesses, and because arsenic, given by the stomach, for a long time upsets the stomach and takes away the appetite.

He uses a mixture containing one part of Fowler's solution and fourteen parts of water, of which he injects at first 80 m (5 grams), morning and evening, and later the same dose three times a day. This treatment may be continued a long time without causing rectal tenesmus. The sole contraindication is a possible diarrhea.

**Action of the Stomach During Sleep.**—Examination of the contents of the stomach obtained in sleep, have convinced SCHULE (*Berl. klin. Woch.*, 1893, No. 50 and 51) that the acidity of the stomach is greater during sleep, and that its motility is lessened. Persons with digestive trouble, therefore, especially if hyperacidity is present, ought not to sleep after eating. Instead, the meal should be followed by wakeful repose.

**Successful Laparotomy for Ruptured Uterus.**—Three hours after labor began in a twenty-one year old, III-para, the membranes ruptured and a hand came down. Two hours later, a midwife made desperate attempts to extract the child by this arm. There was a sudden pain and collapse, with pulse of 128. About two hours later, the abdomen was opened, and the child and placenta found in the peritoneal cavity, the rupture being on the anterior wall of uterus and vagina, and extending into the left broad ligament. The uterus was removed, and its stump treated extraperitoneally.

According to REIN (*Wratsch*, 1896, No. 6), whose case this is, laparotomy has been performed in rupture of the uterus twenty-five times, fifteen times successfully.

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SATURDAY, AUGUST 29, 1896.

## THE PRESENT ADMINISTRATION AT QUARANTINE.

In a position so important as that of health officer of the great port of New York, with duties and responsibilities so delicate, it is peculiarly fitting that the professional public should keep well informed as to what is going on, for in the successful management of the office the medical profession, as well as the public at large, is greatly concerned. Indeed, a mistake here may prove very costly, as history of no very remote date will show; and the entire medical profession will then come in for a share of the blame, which the dear public is ever ready to bestow upon the unsuccessful office-holder. The present administration has clearly taken advantage of certain errors and omissions of the past, and has brought its work to such a high degree of efficiency that to withhold approval would be simply to ignore good work and honest endeavors.

The health officer and his deputies, when on duty, are in uniform; and this, it strikes us, is a distinct gain in the way of producing a good impression upon those with whom they are brought into official contact. The uniform is the badge

of authority, and its presence must impress with the majesty of the law among us those who visit our shores for the first time.

The official headquarters, which were destroyed by fire some months ago, are being replaced by a commodious and tasteful structure, which will soon be completed. Within this building, in addition to offices for general business, will be located a bacteriological laboratory, which is already fully equipped in temporary quarters. The meaning of this laboratory to a conscientious official, and the additional security which the public obtains thereby, cannot be overestimated. A suspicious case of disease appearing upon a ship, a bacteriological examination of the secretions or discharges reveals its character in a few hours with unerring determination, and decides whether the ship may proceed on her way to port or be detained with her passengers and cargo. This fact is not usually appreciated by the general public, and the solution of this question of delay by the present health officer certainly reflects the greatest credit upon him. If a ship arrives after sundown, instead of being obliged to lie at anchor for the night in the lower bay, she is inspected at once and allowed, if in suitable condition, to proceed to her berth. If there are immigrants or others requiring individual inspection, an electric search-light is set up upon the deck, and under its powerful beams the inspection is satisfactorily accomplished. If passengers or cargo require disinfection, the boat, which the health officer has just had constructed, will accomplish it *tute, cito, et jucunde*. A row of bathrooms on either side of the boat will quickly disinfect eight persons by spray or vapor, or both. Clothing, bedding, etc., is all disinfected by steam, *in vacuo*, in a great car, such as is in use by the Board of Health in this city. The cargo itself is disinfected by sulphur gas, which is carried from the disinfecting boat in pipes, under pressure, and distributed where needed, as water is distributed with hose. Thus, a ship, her cargo, and her crew, coming from an infected port could, in a few hours, be sent into the harbor with a clean bill of health, the safety of the public being assured and the rights of the shipping-master protected as well. Surely this is a prodigious advance over old methods.

Should a ship come to our shores, containing many cases of infectious disease—cholera, for example—there would be no long and vexatious detention of the well and clean, together with the sick. The former, after disinfection, would go on their way, and for the latter the health officer has provided large and commodious barges anchored near the quarantine islands, isolation being thus complete and the conditions as favorable as possible for recovery. Of course it is to be hoped that this system may not require the severe test of experience, but if it should, we see no reason to doubt its efficiency. If successful, it would redound primarily to the great credit and praise of the present health officer; it would also be a demonstration to the public that its safety in sanitary matters depends largely upon the endorsement and support of the medical profession.

#### COMPARATIVE PATHOLOGY.

IN these days of the multiplication of special fields in medicine, heavy is the responsibility of the man who dares to add one additional acre to the already continental area which must be kept under cultivation. And yet, this is what appears to have been done in the establishment of chairs of Comparative Pathology by the University of Buffalo three months ago, and by Harvard a few weeks later. The addition, however, is more apparent than real, as the new field is to be opened up not so much in search of new facts as for the purpose of finding a key to many of the facts and problems already in our possession. The aim of the new work is mainly to find the physiological prototype and ancestor of our human pathological processes, or that simpler form of disturbance of metabolism out of which have grown our own more complicated disease-processes. To this end the enormous mass of facts already reported by zoologists, botanists, vegetable pathologists, veterinarians, and agriculturalists, now scattered through a dozen fields and languages, and a hundred journals, must be collected and classified for the use of the human pathologist, and even though the search for the physiological type of human disease be as fruitless directly as that of Ponce de Leon for the fountain of youth, yet like it the fertile continent it

traverses cannot fail to be productive of rich returns in other directions.

Another question upon which new light is to be hoped for, is the dependence of disease upon the structure and developmental history of the part or organ affected. Disease, of course, is simply life out of place, health run mad, pathologic action a mere excess or deficiency of physiologic action, and the varying degrees of development of a given organ in different species can often be shown to determine the disorders to which it is most liable. For instance, the mammalian stomach is essentially a mere sacculization, a local distention in the course of a simple, primitively uniform alimentary tube. Let this distention pass a certain point, however, and we have at once gastric dilatation, (gastromegaly) one of the most obstinate, distressing, and frequent morbid conditions of the organ in our own species. In the carnivora, however, on the one hand, where this physiologic distention has not progressed so far, pathologic dilatation is rare, while in the herbivora, on the other hand, it is not only extremely common, but frequently and rapidly fatal, either from rupture of the already (normally) distended viscus, or from embarrassment of both respiration and circulation by pressure upward of the diaphragm. Again, in the case of the ceco-appendix, appendicitis in the human subject is but an acute (septic) exacerbation of a normal process of wasting and atrophy of this part of the gut, which, as Zuckerkaudl has shown, results in nearly sixty per cent. of cases in its occlusion from the rest of the tube before the fortieth year. And of this charming process we have a proud monopoly. The carnivora are exempt for the good and sufficient reason that they have no appendix (although this region is still a *mauvais terre* and typhlitis is not uncommon) while the herbivora are almost equally so, because in them, instead of a mere "vermiform" remnant, there is present a large, well-developed, and fully functional diverticulum, of equal caliber with the rest of the gut. There appears to be but little hope of our ever having wings in this life or the next—except those of us who are born in Philadelphia—but there is a fair prospect that we may one day get rid of our appendices, which would be a more substantial advantage.

Then again, when a human organ is found peculiarly liable to serious disease, and an examination of the same organ in other mammals reveals an almost equal susceptibility, the inference is strong that this can only be explained by something in the common ancestral history. Take, for instance, the case of the lung, which has already been briefly discussed in these columns. (MEDICAL NEWS, January 11, 1896, p. 49.) Disease of this organ is responsible for nearly one-third of all deaths in our own species; the same thing is true of monkeys, apes, and the carnivora, while its "bad eminence" is only slightly less in the herbivora, and in birds. Now the most striking feature in common in the history of all these beings is their comparative recentness, appearing long after every other organ in the body was perfected except the uterus and mammae. They are the "parvenus," "les nouveaux riches" of the entire body, and hence the least stable, the most easily upset. Furthermore, it is the special regions of this already unstable organ which are undergoing change in form or atrophy that are peculiarly liable to the attack of disease. In the human species it is the right apex, the disappearing "eparterial" lobe, whose presence is attested by the seventh cervical rib in the embryo, in which nearly forty per cent. of all cases of pulmonary tuberculosis have their origin; in the herbivora, the "lower" (posterior) extremity, which is receding before the huge stomach and food-canal, is the commonest site of tubercle.

In cancer the singular immunity possessed by the domestic animals seems most probably explicable on the ground that their sexual functions continue almost as long as life. Uterus and mammae do not, therefore, become senile atrophying foci for this process of anarchy. This cuts down the possibility of cancer in the female sex nearly seventy per cent. at once, while, as these animals seldom long survive their teeth, the lip does not become a supernumerary organ, and the tongue a site of sympathetic atrophy as in our own species. The few authentic cases of cancer reported in dogs have had the disease located at that common "unsettled" borderland, the pylorus, where the ancestral gastric mill, or "gizzard," is still in process of disappearance.

Acne, also, that abortive effort on the part of

our atrophied hair-glands (miscalled "sebaceous") on the most completely denuded parts of our surface, the face and chest, to reproduce at puberty our ancestral hairy covering is practically unknown in any of the lower animals, for the simple reason that they have no denuded surfaces studded with atrophied glands, but all their hair-glands are fully developed and functional from birth or shortly after. It would even seem as if we might hope for some light upon that pathologic puzzle, diabetes, since the essential condition, an excess of sugar in the tissues, has been discovered in certain plants, notably English violets, causing marked edema and a high degree of susceptibility to the attack of a certain fungus which rapidly proves fatal. Similar results were produced in control-plants by the injection of solutions of maltose into the fibro-vascular bundles at the stem. From which it would appear that even "sweet violets" may actually become "too sweet to live."

An interesting, if somewhat misty, field for comparative study is that presented by the nerve branches which are under "anatomical strain," viz.: the recurrent laryngeal, and the spinal accessory. The former nerve, whose course was laid when the heart was literally "in the mouth" and the trachea-lung a mere ventral pouch from the esophagus and which was dragged down by the descent of the heart is liable, in our own species, to both spasm and paralysis to a degree which has never been adequately accounted for upon the grounds either of position, exposure, or physiologic wear and tear. In the horse, where the "dragging down" has been much greater on account of the greater proportional length of the neck, it is peculiarly liable to paralysis giving rise to the symptom known as "roaring." This is produced by the friction of the air against the vocal bands which cannot be adequately separated to admit a large enough column of air to supply the animal at a high rate of speed and is actually obviated in race-horses by the introduction of a large tracheotomy tube. Its prevalence may be judged from the fact that in the recent St. Leger stakes no less than four out of fourteen starters, among whom was the winner, wore silver tubes in their tracheae. In the great majority of

cases it is the left nerve, which passes round the aorta and is thus not only further stretched but exposed to the strain of its heavier pulsations as well, which is affected. Curiously enough, in the giraffe, as Dr. Chapman has reported from the careful dissection of several specimens, this nerve is entirely absent, and the superintendent of one of our largest zoölogical gardens assures the writer that the animal is practically voiceless, or at least that in fifteen years' experience with them he had never known them to make a sound other than a grunt or hiss. One is strongly tempted to connect this singular condition with the enormously elongated neck and consequent "stretching," but it may be merely a coincidence.

There seems to be little question of late that the spinal accessory, with its singularly round-about course from the six upper cervical roots, up through the foramen magnum into the skull, out through the jugular foramen and down to the middle of the sternomastoid nearly opposite its origin, is principally concerned in the production of that distressing and frequent affection, spasmodic wry-neck. Noble Smith declares that in these cases, "section and ablation of a piece of the spinal accessory nerve is absolutely certain to remove all spasm from the muscles supplied by that nerve and very likely to remove spasms set up in other muscles, although other nerves are apparently involved." Here the "anatomical stretching" is due to the development of the neck and consequent subsidence of the shoulder-girdle from the level of the occipital region, and the extreme liability of this nerve to spasm may be a mere coincidence again.

Then again, in the varying intensities of anemia, from simple to pernicious, we have a most perfect series of reversions on the part of the blood toward the lower vertebrate or even invertebrate type. The decrease of red cells, the marked increase of white, the difficulty of maintaining the body-temperature, the appearance of nucleated and even oval red cells (salamandroid), the increase of uric acid, all point in this direction. This is, of course, the merest outline sketch of lines which it might be useful to follow in this work; others will suggest themselves to everyone. The diseases which are common to or

communicable between man and animals, the infections of meat, milk, fish, and vegetables, are of immense interest and importance and are already claiming the attention of a host of skilled investigators. The keynote of comparative pathology is simply that we are a part of all that ever was, that the life of all the ages flows in our veins, and that even in our diseases may be read our pedigree. And its dominant overtone, strange as it may seem, is one of consolation, that the very same processes which make for pain, for disease, and death, also make with tenfold force and frequency for comfort, for health, and for life; that there is no such thing as essential evil in the physical world, whatever there may be in the spiritual.

WOODS HUTCHINSON, M.D.

## ECHOES AND NEWS.

*Sir Spencer Wells' Successor.*—The Queen of England has appointed Mr. Rickman John Godlie, F.R.C.S., Surgeon to the Household in Ordinary to Her Majesty, in place of Sir Spencer Wells, resigned.

*Medical Service of the Paris Exposition.*—Dr. Gilles de la Tourette has been appointed physician-in-chief to the Paris Exposition, to be held in 1900. There will be an exhibit of objects illustrating the progress of medicine and surgery.

*Dr. Samuel Johnson on the Nude in Art.*—Dr. Johnson was not a medical doctor, but one of his sayings was worthy of such an one. It was on the nude in notable paintings of his time. "Sir," said Boswell, "do you consider Mr. Opie's naked Venus indecent?" "No, sir," was the answer, "but your question is."—*Boston Herald.*

*Hospital Surgeon Suspended.*—The Governors of the Sale Hospital, Victoria, Australia, after investigating the complaint of a patient against an honorary surgeon for want of skill and rough handling, voted to suspend him. It was found that, without consultation or trained assistance, the surgeon had performed an operation upon the patient's penis, refusing to use an anesthetic.

*Eucaïn and Cocain Compared.*—In a paper based upon an experimental investigation of the relative effects of these kindred drugs, which Professor Charteris presented to the Royal Society of Edinburgh, he concluded that in aqueous solutions of the hydrochlorates slightly larger doses of eucaïn were necessary to produce lethal effects in guinea-pigs, and its physiological action was slower in onset and less in intensity.

*Ophthalmia in Poor-law Schools of London.*—The Local Government Board has appointed Dr. Sydney Stephenson

to officially inspect the eyes of 20,000 children in the poor-law schools in its effort to free their wards from the fearful consequences of ophthalmia. In 1874 Mr. Nettleship claimed that eighty per cent. of these children were so afflicted, while at present it is thought the percentage is less than ten.

**Gifts to Charity.**—By his will, John W. Gadsden, a well-known veterinary surgeon of Philadelphia, has ordered the major part of his estate, valued at \$50,000, distributed among the several charities of that city. A special bequest of \$5000 is made to establish a free bed, to bear his name, in the Protestant Episcopal Hospital. The apportionment of the remainder is left to the judgment of his executors.

**The Penalty in French Quarantine.**—Death is the penalty for breaking through quarantine in France, according to a law passed in 1822 and still in force. A peasant from the Pyrenees who had returned from Buenos Ayres in a yellow-fever ship and had scaled the lazaret walls at Pauillac in order to get home sooner, has just been on trial for his life at Bordeaux. Though his offense was clearly proved, the jury naturally acquitted him.

**Legal Measures Threatened.**—It seems that the Harvard Evening Medical College and Hospital, of Chicago, has, without authority, announced Professor Edwin Klebs, M.D., as occupying one of its chairs. Professor Klebs has warned it that unless the catalogues containing this announcement are suppressed, he will institute legal proceedings. It is against the same college that Harvard University was recently seeking an injunction to prevent the use of the name Harvard.

**Hebrew Medical Men and the Moscow Congress.**—By reason of the laws of Russia, which discriminate so severely against Hebrews, it was found that all medical men of that race would be prevented from attending the International Medical Congress. A strong communication to the authorities of the Congress, from the German profession, headed by Professor Virchow, has caused the Government to suspend the act as it applies to the visitors to the Congress. It is provided, however, that the passports presented by Jewish members shall be countersigned by a Russian consul.

**Antivenere.**—One of the most interesting scientific questions of the year was brought to the general notice of the profession by Professor Fraser's paper before the British Medical Association upon the antidotal treatment of serpent poisoning by serum, and perhaps more clearly still, in a lecture upon the same subject by Dr. A. Calmette, of the Institut Pasteur, Lille, before the Royal College of Physicians and Surgeons. The practical value of "antivenomous serum" is already being tested in India, with most favorable preliminary reports.

**Privacy for Medical Councils.**—A suggestion made by the *Medical Press and Circular* strikes us at this distance as a very appropriate one. It is that hereafter it would be more in keeping with the time-honored dignity of the profession and better for its well-being and good

name if all medical societies (the British Medical Association included) would conduct their ethical sections in secret, or at least with such privacy that the lay press would be deprived of the opportunity to magnify their occasionally unsavory or sensational proceedings in its daily columns.

**An Overcrowded Hospital.**—Dr. John A. Arnold, the medical superintendent of the Kings County Hospital, at Flatbush, is reported to have made the following statement: "No more patients can be received unless we put them on the roof. A condition similar to that existing here cannot be found, probably, in any other hospital in the civilized world. To say that the building is overcrowded does not describe the actual state of things. It is packed with patients from cellar to attic. It has been out of the question to give each patient a cot. We have to place two cots together so as to make one bed, and three patients are crowded into it. We also have beds on the floor. Why, we even are compelled to put the sick people in the basement. Our great city permits 635 charity patients to be crowded into a building that can accommodate only 250 comfortably."

**Dark Light.**—This is the term employed by a French savant, M. Gustave Le Bon, to denote the photogenic action exerted by the light of a kerosene lamp, an Auer burner, through a sheet of lead, on copper, upon a sensitive plate placed under a negative. The results of the first experiments have since been amply confirmed, and in some instances exceeded by other investigators, especially M. Murat of Havre, who has obtained by this means pictures precisely similar to those brought out under the Röntgen rays. Specimens were exhibited at the last meeting of the Paris Academy des Sciences, and the descriptions read like fairy tales. The most surprising fact in connection with this discovery is that the thickness of the metal or other opaque substance interposed between the light and the negative seems to have no effect upon the success of the photograph.

**Pleuritic Fluid Substituted by Saline Solution.**—Lewaschew first proposed this plan of treatment at the Berlin International Congress. According to the *Therapeutische Wochenschrift*, June 28th, his subsequent success has been marked, and he feels impelled to recommend his plan in stronger terms. His method, in brief, is to substitute an equal amount of saline solution for the pleuritic effusion, and he has now a record of fifty-two cases, all followed by marked relief and prompt recovery. Thoracocentesis is first performed, and as the effusion is gradually aspirated it is replaced by physiologic salt solution, which prevents too rapid expansion of the organs into the empty pleura, while the solution is gradually absorbed and exerts a general tonic and local antiseptic effect. The journal above referred to devotes ten (10) pages to a complete résumé of the results and technic of this treatment.

**Music in a State Asylum.**—Dr. Sylvester, superintendent of the Kings County Hospital for the insane, has hit upon the idea of forming an orchestra out of the employees and inmates of the institution. For some time the superin-

tendent has been trying to get up some sort of a diversion for the patients, and he was interested to learn, several weeks ago, that not a few of his patients were both fond of music and capable of its production. He called for recruits from the army of employees and patients, and soon had a band of sufficient number and unexpectedly good quality. Some of the patients lend themselves readily to the new diversion. A young man twenty-eight years old, who suffers from an acute form of delusions, has become an accomplished artist on the tuba. An orchestra of eighteen pieces will soon be organized, and the players will begin regular rehearsals for the winter entertainments. Thus will the monotonous routine of the long winter months be materially relieved by this new departure. At short intervals Dr. Sylvester plans to give dances, concerts, and other entertainments, in which the musical feature will be given prominence.

**Obituary.**—William C. Benedict, M.D., a retired senior practitioner of Brooklyn, died August 17th, aged seventy-six years. At the time of his demise he was spending the summer at Pine Hill, New York. The cause of his death is assigned to have been due to heart failure, brought on by the intense heat of the previous week. He was born in Schenectady in April, 1820. He graduated from Union College in 1840, and then from the University of Pennsylvania. After his graduation he became connected with the Blockley Hospital for the Insane in Philadelphia, where he rose to the position of chief physician, and remained two years. He then became one of the managers of the insane asylum at Poughkeepsie, N. Y., which place he filled for about a year. In 1844 Dr. Benedict moved to Brooklyn and became prominent during the cholera plague. He is said to have treated the first cholera victim, and was successful in saving his patient's life. Dr. Benedict is survived by two sons and two daughters. His wife died in 1894.—Jerome Cochran, M.D., University of Nashville, and Vanderbilt University Medical Department, Nashville, Tenn., class of '61, died in Montgomery, Ala., August 18th, from chronic nephritis. He was a member of the American Medical Association, State Health Officer of Alabama, as well as a member of the following organizations: American Public Health Association, Alabama Medical Association, and State Board of Medical Examiners. Dr. Cochran was one of the foremost sanitarians in the medical profession, and was the instigator and promoter of all the recent sanitary enactments of the legislature of his State. He was also an ardent advocate of a National Health Bureau. He was a recognized authority on yellow fever, and wrote exhaustively upon that subject.

## SOCIETY PROCEEDINGS.

### BRITISH MEDICAL ASSOCIATION.

*Sixty-fourth Annual Meeting, held in Carlisle, England, July 28, 29, 30, 31, 1896*

(Continued.)

#### SECTION ON OBSTETRICS AND GYNECOLOGY.

On Thursday, July 30th, DR. AMAND ROUTH opened the discussion on

#### SECONDARY PUERPERAL HEMORRHAGE,

which he defined as that which occurred after the doctor had left the house and after firm uterine contractions had once occurred. Whether concealed or external, he regarded retained portions of placenta or membranes as the most frequent cause, although it might occur from inertia or detachment of thrombi. Other speakers suggested as possible causes bleeders, intrauterine fibroids and distended bladder. The treatment suggested was emptying the uterus, bimanual compression supplemented by hot douches, and the hypodermic injection of ergotin. Dr. Donald said that he had seen several cases of free uterine bleeding with toxic symptoms about the ninth day, from overfeeding and constipation. For these he recommended purgation. Intravenous injections of saline solutions were suggested for cases of exsanguination. Compression of the abdominal aorta is sometimes advisable. The importance of curettage was also mentioned.

#### DR. BERRY HART read an interesting paper upon THE SYMPTOMS AND NATURE OF THE SO-CALLED FLESHY MOLE,

which was illustrated by diagrams and specimens. Dr. Fothergill remarked that the terms "blighted ovum" and "fleshy mole" might be applied to two varieties of missed abortion, but in the latter the effusion of blood, which was absent or unimportant in the former formed a clot and was gradually organized. Dr. Cameron showed a preparation of the fleshy mole with an early embryo, and indulged in some remarks upon the medico-legal aspects.

#### DR. JOHN D. WILLIAMS presented a paper on ANTI-STREPTOCOCCIC SERUM IN THE TREATMENT OF THE PUERPERAL SEPTICEMIA.

In the cases reported it gave unsatisfactory results.

On Friday, the 31st, the subject for discussion, presented by DR. MILNE MURRAY, was

#### THE RELATIVE ADVANTAGES OF FORCEPS AND VERSION AS A MEANS OF EXTRACTION IN CASES OF MODERATE PELVIC CONTRACTION.

In illustrating the methods of instrumentation, Dr. Cameron showed Smellie's first pair of wooden forceps. Dr. Murray's advocacy of axis-traction was generally commended by the several speakers.

DR. CHRISTOPHER MARTIN then read a paper on

#### HEMATOMETRA AND PYOMETRA,

based upon six cases. He stated that he had never met a case of hydrometra, but that accumulation of blood or pus in the womb was rare, dangerous, and difficult.

Dr. Cameron presented a paper on retroversion of the gravid uterus, with a new method of treatment, and Dr. Fothergill read a paper on Walcher's position, in which he recalled the fact that years ago Matthews Duncan had described and figured the nutation of the sacrum.

#### SECTION ON PATHOLOGY AND BACTERIOLOGY.

On Thursday the proceedings opened with a paper by DR. J. S. HALDANE upon

#### COAL-GAS POISONING.

In recent investigations he discovered that carbon monoxid was not a protoplasmic poison, like carbon

dioxid, but acted simply by preventing oxygen from combining with hemoglobin. He said that a great public danger was developing in the tendency of gas companies to adulterate their coal-gas with water-gas. The supply now often contained from eighteen to twenty per cent. of the latter instead of five or six per cent.

Dr. Alexander Scott spoke of the effect of the "clear gas" found in ammonia factories, which consists of the two oxids of carbon, in its effect upon the nervous system. Dr. Haldane, in further discussion, stated that it was useless to give oxygen to patients when more than an hour had elapsed after exposure to the gas.

PROFESSOR FRASER'S paper on

#### THE LIMITATIONS OF THE ANTIDOTAL POWER OF ANTITOXINS

was next read, though the author was not present. He gave an account of his methods of standardizing antivenene, and gave as his opinion that the reaction of this substance was due to the formation of a chemical antitoxic product in the blood. With this view Professor Calmette differed, and thought it due to the susceptibility of the protoplasm of animals to the toxins of venom.

Dr. Risien Russell followed with a contribution to our knowledge of afferent and efferent tracts in the cerebellum, in which some facts relating to the influence of that organ upon the cerebrum were extremely well brought out.

On Friday the discussion was less active. The first subject presented was

#### THE RELATION OF THE MORBID CONDITIONS ASSOCIATED WITH THE PRESENCE OF STREPTOCOCCI.

Dr. Woodhead spoke of the great prevalence of microorganisms in explaining the vast number of diseases caused by them. Six varieties of streptococci were recognized from the difference of their products, their structure and appearance being the same. He spoke of the virulence of cultivated cocci produced by Marmorek's method, and suggested that the varying conditions of the tissues might account for the difference in virulence developed from the same organism in different cases. He said that each streptococcus is capable of existing in two forms—first as a saprophyte, when all of its energies are devoted to the production of its kind, and secondly as a parasite, when it is fighting for its own existence. It is in this latter phase that toxins are elaborated. Dr. Muir suggested that the only real test of the identity of two microorganisms was to immunize with one and observe if injection of the other was ineffectual.

#### SECTION OF OPHTHALMOLOGY.

This Section was introduced on Wednesday, July 29th, by an address from the president.

#### THE PATHOLOGICAL ANATOMY OF VARIOUS TISSUE CHANGES AT THE MACULA LUTEA, AND OF CERTAIN FORMS OF KERATITIS

was presented by PROFESSOR NUEL of Liege. This was a most important contribution, and in his microscopic demonstrations of albuminuric retinitis, glaucoma, and detachment of the retina, marked changes were shown in the layer of Henle. In some cases the edema of this layer was limited to the macula. He further showed that in

toxic amblyopias, contrary to the common opinion, the primary change was in the macula, and the nerve changes were in the nature of ascending degeneration. The view that this condition is due to a retrobulbar neuritis must, therefore, now be given up. The specimens relating to forms of keratitis were not wanting in interest.

The paper upon

#### THE PATHOLOGY AND BACTERIOLOGY OF PURULENT KERATITIS,

by PROFESSOR UHTHOFF and DR. AXENFELDT, was presented, in which they regarded *ulcus serpens* as due to an infection of Fraenkel's pneumococcus.

DR. CECIL SHAW read a paper recounting

#### EXPERIMENTS MADE UPON THE CORTEX OF THE OCCIPITAL LOBES IN MONKEYS.

Hemiopia was noted in all cases.

#### THE OPERATIVE TREATMENT OF HIGH MYOPIA

was presented by MR. LAWFORDE, who stated that eyes with less than 11 D. or 12 D. of myopia were unsuitable cases for operation, and the use of this method should be governed, in a large degree, by the health, social environment, and duties of each patient, as well as the condition of the eye itself. Van Hippell had reported cases of successful operation upon eyes presenting 35 D. to 50 D., and it might, therefore, be concluded that there was no limit to the degree of error suitable for this method, provided the condition of the eye itself was favorable. In the lens extraction he had abandoned the preliminary iridectomy as the circular pupil was more important in these cases than in those of senile cataract. Only four out of sixty-eight cases operated upon gave an unfavorable result. Mr. Cross regarded detachment of the retina as due to senile changes rather than myopia, and related his experience with the operative treatment of the latter. Mr. Percival demonstrated by optical formulæ that in aphakia the posterior pole of the eye should be situated 31.1 mm. behind the cornea in order that the eye should be emmetropic. In closing this discussion Mr. Lawford presented the question as to whether a child of ten years of age with 8 D. or 9 D. of progressive myopia should be operated upon, or should wait for further development of the error, the unfavorable pathological changes continuing meanwhile.

On Thursday, DR. MAXWELL of Dublin, presented a paper based on one hundred and sixty-eight cases of

#### CONVERGENT SQUINT,

in which he discussed precision in squint operations. Seventy-one per cent. of these cases occurred before the age of three years, and the average refraction of each eye was + 3 D. The average degree of squint measured in angles by the perimeter was 30°. In fifty-seven cases a simple tenotomy was performed, which reduced the squint on the second or fourth day after the operation by 17.5°. When again tested, on the fourteenth day afterward, the reduction was found to be about 15°. When the sound eye was subsequently tenotomized, the final retraction was found to be greater than the primary. He then described a new method of operating for which a special

instrument was necessary, which showed on a scale how much the tendon was raised from the globe, and was intended to indicate, during the operation, how great a shortening might be anticipated. The amount of squint that an eye should have when entirely due to hypometropia was 3° for each diopter. Professor Landolt pointed out that squint depended essentially upon the innervation from the convergence-center, and not upon an anomaly of the converging muscles, and said that the credit for cure was rather to be attributed to the *vis medicatrix naturæ*, than to the surgeon who set back a muscle a definite number of millimeters. The object of the surgeon should be to strengthen the weak muscles rather than to weaken the strong. An advancement operation, therefore, is preferable to a tenotomy. In closing, Dr. Maxwell said that he allowed 5° of squint to remain when operating.

#### SNELLEN'S OPERATION FOR EXTRACTION OF SENILE CATARACT

was then discussed in a paper by DR. BERRY. The special feature of the operation was an incision occupying half the corneal margin with a large conjunctival flap. He recommended the operation strongly, stating that the anterior chamber was usually reformed in an hour or two, and that prolapse of the iris did not occur except occasionally during the operation, when it was easily replaced. Mr. Cross of Bristol, thought healing took place more readily when the conjunctival flap was made, but found the hemorrhage sometimes troublesome.

Visceration was advocated by Mr. Bickerton.

MR. LAWFOORD read a paper upon

#### THE FORMATION OF AN ARTIFICIAL PUPIL BY EXTRA-OCULAR IRIDOTOMY,

an operation devised by Schöler.

#### THE CURE OF OBSTRUCTION OF THE NASAL DUCT

was discussed by MR. BICKERTON, who advocated the use of hollow silver stiles, which were suggested by Dr. Fox of Philadelphia. These might be worn for years without discomfort.

On Friday DR. MAXWELL read a paper treating of the EFFECTS OF NASAL OBSTRUCTION ON ACCOMMODATION.

He gave details of five cases in which cure of accommodative asthenopia followed treatment directed to the nasal passages alone. He thought the condition was brought about by reflex nervous influences traveling through the fifth and long ciliary nerves. Dr. Batten discussed the relationship between the two conditions, which he had frequently observed.

DR. EDGAR STEVENSON presented a paper upon

#### THE TREATMENT OF CORNEAL OPACITIES BY ELECTROLYSIS.

He used a current of  $\frac{1}{4}$  to  $\frac{1}{2}$  milliamperes and a pressure of 3 volts. The anode was placed on the cheek of the opposite side, and the cathode, consisting of a smooth silver probe, was applied to the corneal opacity and gently moved over the surface. An amperemeter and rheostat should always be used, and great care exercised that the current does not exceed  $\frac{1}{4}$  milliamperes. Cases illustra-

ting the success of this method were presented. Not more than fifteen consecutive applications should be made, as there was danger of softening the cornea.

#### DISEASES OF CHILDREN.

The first subject discussed was

#### THE ELEMENTS OF SUCCESS AND FAILURE IN TRACHEOTOMY IN CHILDREN,

by DR. CAMERON. One of the first elements upon which success might be based was that of late operation, in his estimation, because in the latter stages there was less danger of wound infection, and the case was more nearly convalescent when the operation was done. By strict conformity to the middle line, bleeding was more readily avoided, and a clear view of the tracheal rings should be gained before opening the wind-pipe. The speaker had observed two cases of prolapse of the thymus gland into the lower angle of the wound. Mr. Tubby suggested that age was an important factor in the success or failure of tracheotomy, a patient under one year of age seldom recovering, and the prospect of success rising with every year of the child's life. He regarded it as important that the head and neck be kept in a straight line, and that the retractors be assigned to one person only. The tube should be permanently out of the throat by the fourth day at the latest. He also advocated the removal of the silver tube after the first day, and replacing it by a rubber one, which should be worn only a few days. Dr. Simpson was interested in Dr. Cameron's suggestion of late operations. Dr. Renton expressed a highly favorable opinion of intubation, which he had practised with success. The steam-kettle was condemned as reducing the vitality of the child.

DR. HUNTER MACKENZIE presented a paper on

#### PAPILLOMA OF THE LARYNX IN CHILDREN.

On Thursday, July 30th,

#### SPORADIC CRETINISM

was introduced as the subject for discussion, in which DR. PARKER first took part, and exhibited the photographs of forty-eight cretins which he had collected. Dr. Thomson of Edinburgh, demonstrated by photographs great improvement from the thyroid treatment in children, less in adults. Mr. Victor Horsley showed a slide illustrating a case of intrauterine rickets in a case of cretin. Dr. Beach spoke of the causation, a neurotic inheritance being a chief factor. As to sex, in a collection of cases made by him, forty-three were males, and seventy-three females, which contrasted with the relative frequency of occurrence of myxedema. In sixteen cases examined *post-mortem*, there was absence of the thyroid. Dr. Thomson further mentioned that his cases, treated by the fresh gland, did better than those treated by the tabloids.

On Friday, DR. JOHNSTONE CAMPBELL presented a paper entitled

#### THE ADVANTAGES AND DISADVANTAGES OF USING STERILIZED MILK.

Heat he considered the only safe treatment to render milk germ-free. The advantages of raw milk were that the fats were more digestible, the salts more assimilable.

and the casein more digestible, and the taste nicer. The disadvantages were the risks of contamination with germs of disease. To prevent the latter, he gave extended directions as to the care of cows and the dairy in general. Dr. Coley regarded the tubercle bacillus the first and greatest menace in the use of raw milk. Dr. Carmichael considered that they were far behind Continental and American methods, and hoped the discussion would pave the way for a more active public knowledge of this subject, and the provision of centers where sterilized milk could be procured. He regarded Pasteurization of milk as sufficient for all ordinary purposes. Dr. Church urged that milk sugar should be the only sugar added to milk, as it was better for the child.

#### BACTERIOLOGY OF INFANTILE DIARRHEA,

was the subject of a paper presented by DR. MACFAYDEN, and

#### IMPERFORATE RECTUM,

was discussed by DRs. ROSS and SIMPSON.

### NEW YORK COUNTY MEDICAL ASSOCIATION.

*Stated Meeting, June 15, 1896.*

The President, JOSEPH E. JANVRIN, M.D., in the chair.

J. LEWIS SMITH, M.D., read a paper entitled

REMARKS ON NASO-PHARYNGEAL INFLAMMATION.

(See page 225.)

#### DISCUSSION.

DR. FRANCIS J. QUINLAN said that in all cases of nasopharyngeal inflammation it was important to determine by a careful local examination the parts which were affected by the disease. It was well, therefore, to explore the entire length of the nasopharyngeal tract. It was a fact that many of the cases of more or less chronic diseases were due to nasal stenoses of one variety or another. To determine the exact location of the stenosis required a careful exploration, and for this purpose it was generally necessary to make a preliminary application of cocaine to the mucous membrane. Sometimes we found cartilaginous hypertrophy, sometimes polypous growths, and sometimes various other conditions giving rise to stenosis.

The nose had four functions to perform: (1) to purify and filter the air inhaled; (2) to saturate the air with moisture; (3) to warm the air; and, (4) to act as the organ of smell. It could be seen, therefore, that the nose had a very important part to perform in rendering the air inhaled of a suitable condition to be taken into the lungs. If there was any obstruction in the nasal tract the air inhaled was taken in through the mouth, and the most serious consequences were liable to result.

If there was no obstruction of the nose itself there might be some interference in the naso-pharyngeal space. One of the most frequent of these was a chain of masses of adenoid, or, more properly, lymphoid tissue, making a complete circle at the base of the tongue. By means of this obstruction the whole physiological process of breathing was converted into a pathological one.

As a result of neglect to remedy this condition we saw numberless children with open mouths and expressionless

countenances, whose mental development was seriously interfered with. Such children always slept badly and were liable to attacks of croup, to nocturnal enuresis, to diarrhea, and various digestive disorders, and to a large number of neurotic conditions, including chorea. The nose was the gateway to the lungs, and if it did not properly fulfil its functions the individual must inevitably suffer. If it were asked why a child with such obstruction should have attacks of croup, etc., at night, and not in the daytime, the answer was because at night the nares were more constricted. The blood vessels were interfered with, there was pressure at the base of the brain, and the sphincters were relaxed.

As a rule, children with this adenoid obstruction bolted their food. In consequence, the process of digestion was usually interfered with, and rachitis, with its pigeon breast and long train of attendant evils, was exceedingly apt to be developed. Moreover, many of the serious conditions, which are met with in adults, were simply the results of nasopharyngeal obstruction during childhood. Of course, there might be traumatism, but it was a fact, unfortunately, that the obstructive conditions here referred to were too frequently overlooked until almost irreparable damage had been done. In his paper, Dr. Smith had treated of diphtheria and various other acute diseases which had their primary seat in the nasopharyngeal tract. It could be readily seen that a disordered tract was only too ready to receive infections from whatever source, and that a child which did not breathe properly (whether the obstruction was due to enlarged tonsils, adenoid proliferation, or other trouble), would be much more liable to contract such acute diseases than one whose respiratory apparatus was in a normal physiological condition. He had no doubt also that the various forms of malignant disease are more easily contracted by individuals whose nasopharyngeal tracts were diseased.

DR. J. R. MACGREGOR said that his own observations corroborated the experience of Dr. Quinlan, and he had only one or two reflections to present the effect of acute inflammations, as represented by diphtheria, influenza, etc., on the nasopharyngeal passages was of more importance, he believed, than was generally supposed to be the case. Having personally gone through several attacks of influenza (one of them last autumn), he appreciated very thoroughly the peculiarly irritating character of the mucous and muco-purulent discharges which were so distressing to the patient suffering from that disease. His own experience led him to substantiate the statements of Dr. Smith as to the importance of thoroughly cleansing and disinfecting the cavities in these acute disorders. Another fact which he had observed was that they led to a peculiar form of rhinitis, which is liable to become chronic, and in children, especially, to atrophic rhinitis. At the Metropolitan Throat Hospital, with which he was connected, he had been surprised at the comparatively large number of children, of eight or nine years of age (sometimes even of only six), who suffered from atrophic rhinitis. The importance of being alive to the liability of this danger, seemed to him to be very great. If proper treatment were commenced early enough, many could,

no doubt, be saved from ozena. It had formerly been supposed that atrophic rhinitis followed in the wake of hypertrophic rhinitis, but this was certainly not the case, especially in the young.

Another speaker said that the statements made by Dr. Quinlan seemed to him to be somewhat confusing. The doctor had attributed all sorts of disorders to adenoid disease, but his opinion was that, while undoubtedly it did sometimes cause these reflex troubles, it was only one of a variety of causes. When, therefore, we operated for the removal of this adenoid tissue, we should make it a point never to guarantee relief to our patient, since there might be some other factor at the bottom of the trouble. He then proceeded to speak of the treatment of acute nasopharyngeal catarrh, or ordinary "cold in the head." During the past winter, both in private and hospital cases, he had tried all of the various remedies, which have been lauded in this condition, and he had found that, one by one, they had failed in the test. Among the agents which he had employed were quinin, tartar emetic, squill, antiseptic douches, eucalyptus, menthol, etc. Only a few patients who were the subjects of cardiac disease and were resting in bed got well in a marvelously short time. This result, he thought, could be attributed only to complete rest in bed and to massage, which was practised three times a day. In addition, the room occupied was kept at an even temperature. All these patients recovered from their catarrh within about forty-eight hours.

If the patient could not, or would not, rest in bed, local treatment might be resorted to, but it did not seem to make much difference what agent we used in the nasal douche. Salt and hot water, borax, boracic acid, or salicylate of soda, in the proportion of a dram to the pint, would do as well as anything else. The patient should always be carefully warned against allowing any of the fluid to get into the Eustachian tube. To avoid this, the vessel containing the solution used should not be held higher than six inches above the nose, the head should be held forward, with the mouth open, and the patient should resist the first tendency to swallow the liquid. It would be found that the frequent removal of the discharges would afford a great deal of relief. Sometimes when the nares were very much obstructed, it was desirable to inject into them a one per cent. solution of cocaine at the commencement of the treatment, but this should always be done by the physician himself. Later, such agents as menthol, benzol, etc., might be resorted to with more or less benefit. General treatment was unimportant, except in cases not treated by rest at the outside. The most important class of remedies were tonics, such as cod-liver oil, malt extracts, etc.

Dr. Smith, in closing the discussion, said his chief object in writing the paper, which he had read, was to elicit the opinions of specialists upon the importance of nasopharyngeal inflammations which the general practitioner often overlooks or considers secondary. What he had heard had confirmed him in his opinion in regard to their importance and the necessity of local measures either alone or in conjunction with constitutional treatment.

At the social reunion after the meeting, which was the

last one of the Association before the summer vacation, remarks were made by ex-Presidents John Shrady, S. R. W. McLeod, J. R. MacGregor, and George T. Harrison.

## CORRESPONDENCE.

### THE MEDICAL NEWS AND QUACKERY.

To the Editor of THE MEDICAL NEWS:

DEAR DOCTOR: It is a pleasure to express my thanks and gratitude for the vigorous opposition you have made to the experiment of treating inebriety by secret drugs at Bellevue Hospital. A similar criticism and denunciation of gold-cure specifics by two London journals broke up a great charlatan scheme, and received the warmest praise and endorsement of the British medical public. An independent medical press, not afraid to expose frauds and defend common-sense views of practical medicine, is always welcomed by the profession. The NEWS, by its just criticism of this matter, has won an enviable place in medical journalism, which, I am sure, will be remembered for a long time to come.

Again thanking you, believe me

Yours truly,

T. D. CROTHERS, M.D.

HARTFORD, CONN.,  
August 22, 1896.

### OFFICIAL LIST OF THE CHANGES OF STATION AND DUTIES OF MEDICAL OFFICERS OF THE U. S. MARINE HOSPITAL SERVICE, FOR THE 16 DAYS ENDED JULY 31, 1896.

CARTER, H. R., Surgeon, directed to inspect Marine Hospital at Tampa, Fla., July 28, 1896.

PECKHAM, C. T., Passed Assistant Surgeon, directed to report to Surgeon Godfrey, Chairman of Board for Physical Examination, July 24, 1896.

BROWN, B. W., Passed Assistant Surgeon, granted leave of absence for six days, July 23, 1896.

STEWART, W. J. S., Passed Assistant Surgeon, granted leave of absence for four days, July 17, 1896.

DECKER, C. E., Assistant Surgeon, to proceed from Battle Creek, Mich., to St. Louis, Mo., for duty, July 21, 1896.

PROCHAZKA, EMIL, Assistant Surgeon, granted leave of absence for twenty days, July 23, 1896.

### BOARD CONVENED.

Board convened to meet at Port Townsend, Wash., for the physical examination of Passed Assistant Surgeon C. T. Peckham, Surgeon John Godfrey, Chairman; W. G. Stimpson, Recorder, July 24, 1896.

### PROMOTION.

BANKS, C. E., Passed Assistant Surgeon, commissioned as Surgeon, July 27, 1896.

### DEATH.

FESSENDEN, C. S. D., Surgeon, died at Salem, Mass., July 23, 1896.

### OFFICIAL LIST OF CHANGES IN THE STATIONS AND DUTIES OF OFFICERS SERVING IN THE MEDICAL DEPARTMENT, U. S. ARMY, FROM JULY 28, 1896, TO AUGUST 3, 1896.

The leave of absence, on account of sickness, granted Major James C. Worthington, surgeon, is further extended one month, on account of sickness.

Leave of absence for one month, to take effect on or about August 5, 1896, is granted Major Henry McElderry, surgeon, Fort Robinson, Neb.